

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11001 CERTIFICATE OF DEATH

REG. NO. 68-11001

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Rosetta Butler (DENT)</i>		2. DATE AND HOUR OF DEATH <i>10/30/68</i> <i>2:15</i> a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore County</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> <i>London Avenue</i> <i>Baltimore, Maryland</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <i>F</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>4-20-03</i>	
13. FATHER'S NAME <i>Lewis Best Dent</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca James Weems</i>		9. AGE (In years last birthday) <i>65</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-3436</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
17. INFORMANT <i>Husband</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intestinal Obstruction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>Adeno carcinoma Colon</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>10/25/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>10/25/68</i> to <i>10/30/68</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>10/30/68</i> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <i>M.L.S. Brown, M.D.</i>				23B. DATE SIGNED <i>10/30/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>M.L.S. Brown, M.D.</i>				23D. ADDRESS <i>Maryland General Hospital Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-2-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1968</i>			
25B. NAME OF REGISTRAR <i>Charles R. Law</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>			
25D. ADDRESS <i>802 Madison Ave.</i>					

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 68-11002 CERTIFICATE OF DEATH

REG. NO. 68-11002

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sister Valerie Nee: Leah F. Fitzhugh		2. DATE AND HOUR OF DEATH 10-25-68 12 Noon	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Little Sisters of the Poor 1200 Valley St., Balt. Md. 21202			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8. COUNTY 10-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1200 Valley St.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1900	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10B. KIND OF BUSINESS OR INDUSTRY 666		11. BIRTHPLACE (State or foreign country) Manchester England	
13. FATHER'S NAME James Fitzhugh			14. MOTHER'S MAIDEN NAME Elizabeth Ellen Riley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-54-1716		17. INFORMANT Little Sisters of the Poor	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary edema. DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 416X II		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to Oct 25, 1968 , that (I) (we) last saw the deceased alive on Oct 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas			23B. DATE SIGNED 10.26.68		23C. PHYSICIAN'S NAME (Type) Stanley Ankudas, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 10/28/68		24C. NAME OF CEMETERY or CREMATORY Cathedral
24D. LOCATION (City, town, or county) Baltimore			24E. ADDRESS 1101 Maiden Choice Lane Balt. Md. 21229		24F. NAME OF REGISTRAR Philip Herurgans
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968			25B. NAME OF REGISTRAR Philip Herurgans		25C. FUNERAL DIRECTOR 2024

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO.

VS 150-REV. 1/1/68

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11004				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11004		
1. NAME OF DECEASED (Type or Print) LOYD G. HENDERSON				2. DATE AND HOUR OF DEATH OCT. 29, 1968 9:35 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 11-8-68				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2057 N. Bentalou Street 817 E. CHASE STREET				
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1930	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lloyd Glenford Henderson Sr.				14. MOTHER'S MAIDEN NAME Marie B. Tyson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1948-1968		16. SOCIAL SECURITY NO. 218-22-2259		17. INFORMANT ADDRESS Isabelle J. Henderson-2025 N. Bentalou Street				
18. 730.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIAC ARREST (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 330 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBARACHNOID HEMORRHAGE 9 DAYS (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION ? (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from OCT. 20 1968 to OCT. 29 1968 , that (I) (we) last saw the deceased alive on OCT. 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE John R. Sobotka				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED OCT. 29 1968		
23C. PHYSICIAN'S NAME (Type) JOHN R. SOBOTKA				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/68		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Robert E. Tjebkema		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		ADDRESS		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11005

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES Louis ROBERTSON Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> October 26, 1968 Hour 4:05 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA) (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour October 26, 1968 4:05 A.M.	
6. SEX male	7. RACE negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-06	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
9. DATE OF BIRTH May 15, 1935 10. AGE (In years lost birthday) 33 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1917 W. Longwood Street	
11. BIRTHPLACE (State or foreign country) Meridian Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Sparrows Point	
15. FATHER'S NAME Norman Robertson Sr.		15. MOTHER'S MAIDEN NAME Ethel Mae Campbell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes -1958		17. SOCIAL SECURITY NO. 217-30-2823	
18. INFORMANT Mrs. Margaret T. Robertson		ADDRESS 1917 N. Longwood St.	
19. E9661X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Stab Wounds (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? North & Ellamont Avenues		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10/26/68 3:00 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. stabbed by unknown assailant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) DATE SIGNED 10/26/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/31/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		ADDRESS	

WALLEN PAPER

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R-152

68-11006 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11006

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lucia Harper ROBINSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 30 68 6:00 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3604 Clifton Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour October 30, 1968 6:00 a. M.	
6. SEX Female		7. RACE Colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH July 22, 1908		10. AGE (In years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) Lexington, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Sarah Adams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. None		18. INFORMANT Mr. Vernon Robinson-3604 Clifton Ave.	
19. 493X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Asthma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type)		DATE SIGNED October 30, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore CO. Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave.	

WALLEY PAPER
WALLEY PAPER

FUNERAL DIRECTOR: IMPORTANT

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68-11007 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11007

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CELESTINE DIXON		2. DATE AND HOUR OF DEATH 10/29/68 145 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 17-03	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY OF MD. HOSP BALTIMORE, MD. 21201				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 838 HARLEM AVE	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/19	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ELMER DIXON			
14. MOTHER'S MAIDEN NAME EVA GRANT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Chart			
18. 590.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC PYELONEPHRITIS		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MO. 7 YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 600.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 1961 to OCTOBER 29 1968 , that (I) (we) last saw the deceased alive on OCTOBER 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David L. Halstead</i>				23B. DATE SIGNED 10/29/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/2/68		24C. NAME of CEMETERY or CREMATORY Carver Mem Park	
24D. LOCATION (City, town, or county)		24E. ADDRESS (State)		24F. ADDRESS (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR <i>David L. Halstead</i>		25C. FUNERAL DIRECTOR Irvin Carroll, Halstead Funeral	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	

James Dixon

Carl Smith

Charles H. Thompson

Joseph H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11008 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11008

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DOROTHY BELL		2. DATE AND HOUR OF DEATH 10/29/68 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-04		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			STREET AND NUMBER 2556 Boyd St.		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-27	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Brown			14. MOTHER'S MAIDEN NAME Sadie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT From chart	
				ADDRESS From chart	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Terminal Ca.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastases to lungs (B) DUE TO, OR AS A CONSEQUENCE OF: Primary Ca cervix (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 171X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/28/68 to 10/29/68 , that (I) (we) last saw the deceased alive on 10/29/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. S. Ming				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) CHEE SHWE MING				23D. ADDRESS Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/68		24C. NAME of CEMETERY or CREMATORY Western Star Cemetry Catonsville Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Reg. 58, J. L. Jones		25C. FUNERAL DIRECTOR I Carroll, 1206 W North Ave	
				ADDRESS Halstead Funeral Home	

Nov 11, 1954

1954-1955

4 12-2-1

VALENTINE

CERTIFICATE OF DEATH

REG. NO.

68-11009

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)LISOWSKY
Barbara Sacharuk

2. DATE AND HOUR OF DEATH

30 Oct 68

5⁵⁰ P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVE.
BALTO. MD. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MARYLAND B. COUNTY BALTIMORE

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

705 OAKLEIGH BEACH RD. 21222

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

12-16-92

9. AGE (In years last birthday)

75

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED LABOR

10B. KIND OF BUSINESS OR INDUSTRY

CROWN CORK SEAL

11. BIRTHPLACE (State or foreign country)

POLAND UKRAINE

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

FEODOR BARHOWSKY

14. MOTHER'S MAIDEN NAME

UNIK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-07-7875A

17. INFORMANT

BCH RECORDS: 4940 EASTERN AVE. 21224

ADDRESS

18.

436.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular accident

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 1/2 yr

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

331 X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from Oct 30 19 68 to Oct 30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (X) (we) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Riley M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

30 Oct 68

23C. PHYSICIAN'S NAME (Type)

David J. Riley M.D.

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 Eastern Ave Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

NOV 2 1968

24C. NAME OF CEMETERY or CREMATORY

HOLY TRINITY CFM

24D. LOCATION (City, town, or county) (State)

ELK RIDGE

BALTO MD.

25A. DATE REC'D BY HEALTH DEPT.

NOV 1 1968

25B. NAME OF REGISTRAR

Robert E. [illegible]

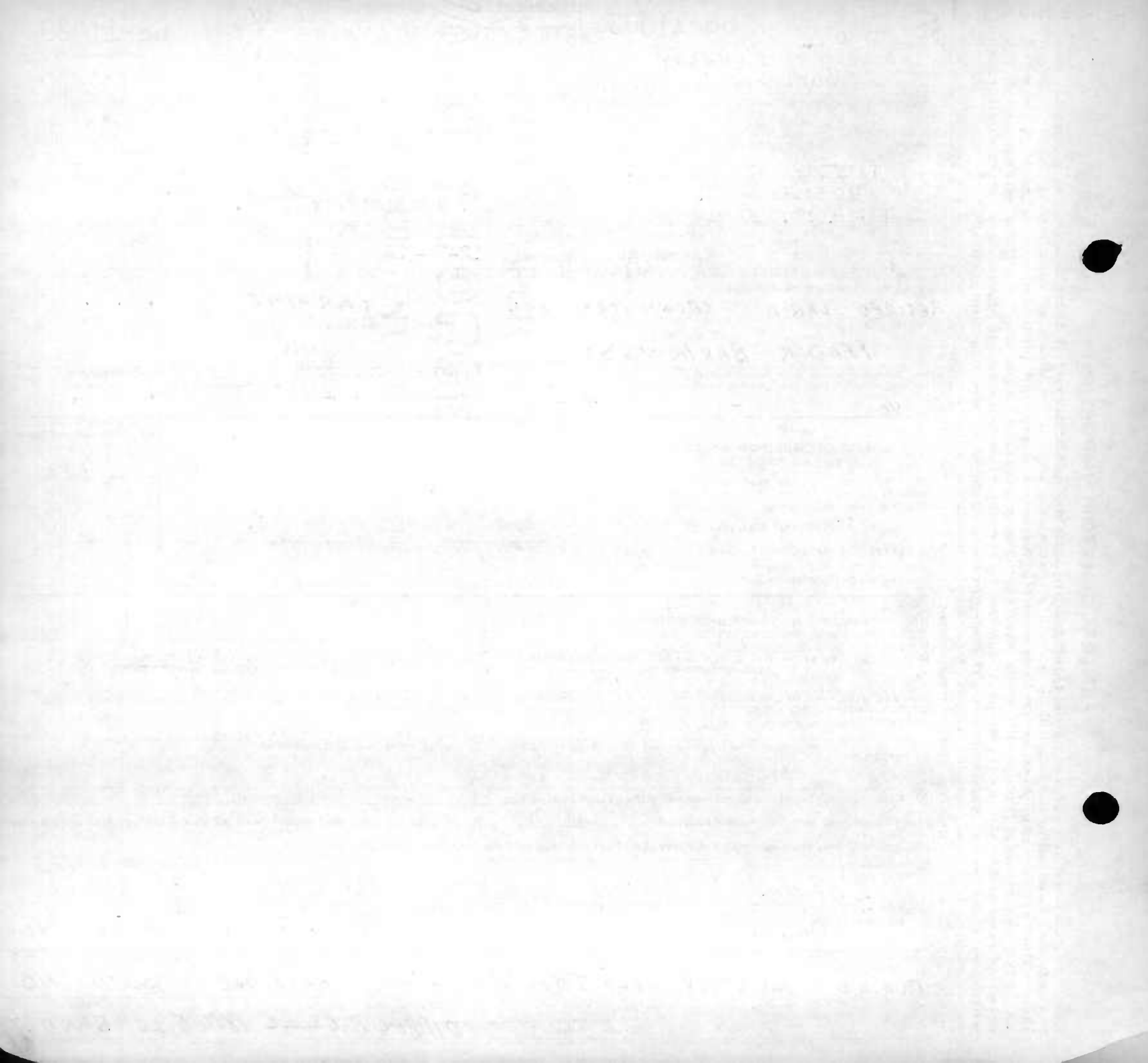
25C. FUNERAL DIRECTOR

DIRREL BROS INC 1800 E LOMBARD ST

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



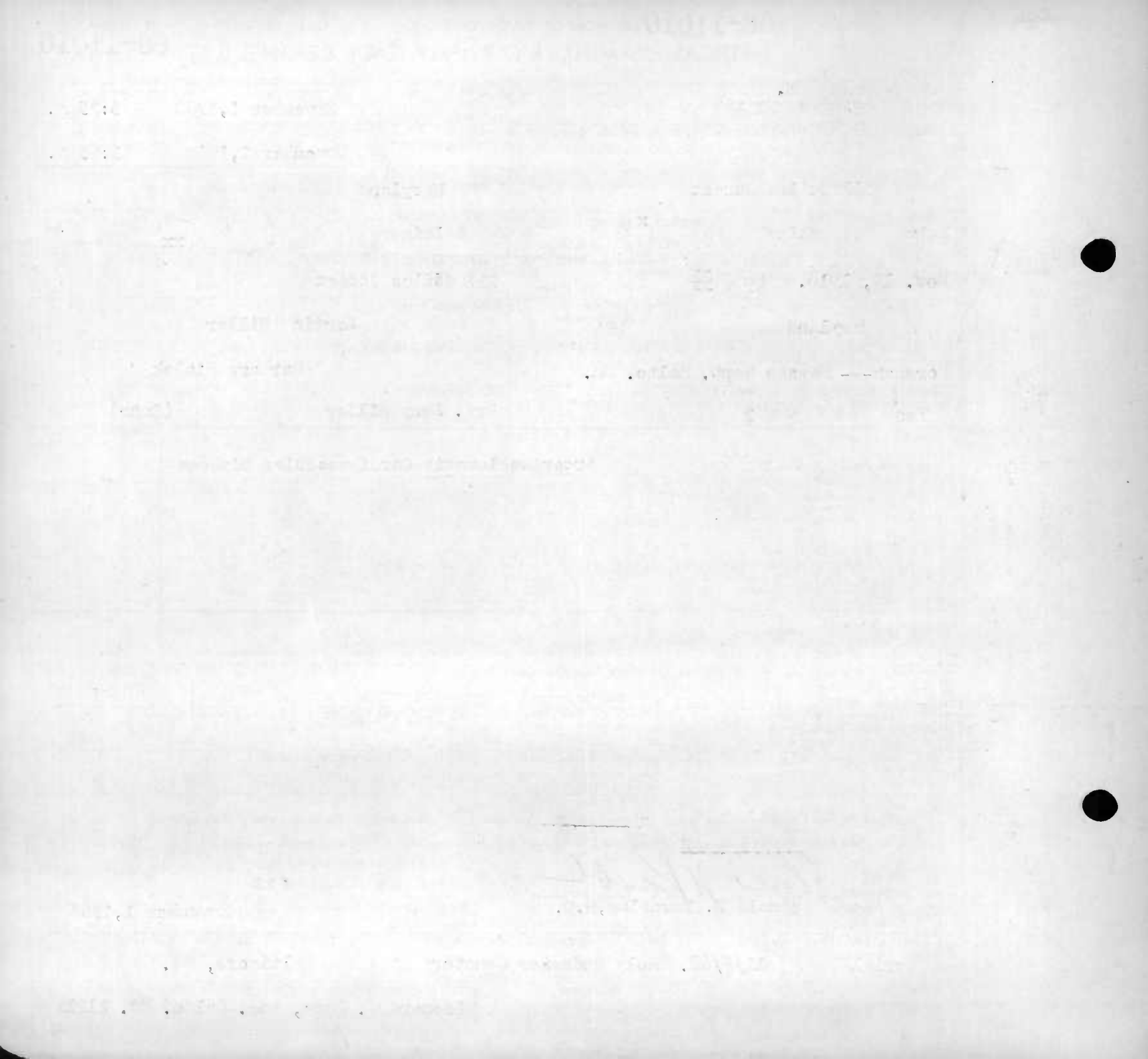
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11010

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) TADEUS MILLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 1, 1968		Hour 3:25 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 917 Stiles Street		3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968		Hour 3:25 A.M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY				
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Nov. 19, 1918.		10. AGE (In years last birthday) 49	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 917 Stiles Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman--- Sewage Dept. Balto. Md.		15. MOTHER'S MAIDEN NAME Barbara Bialek		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Lucy Miller
19. 712.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> - Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 1, 1968
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/68.	24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Regis. J. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214



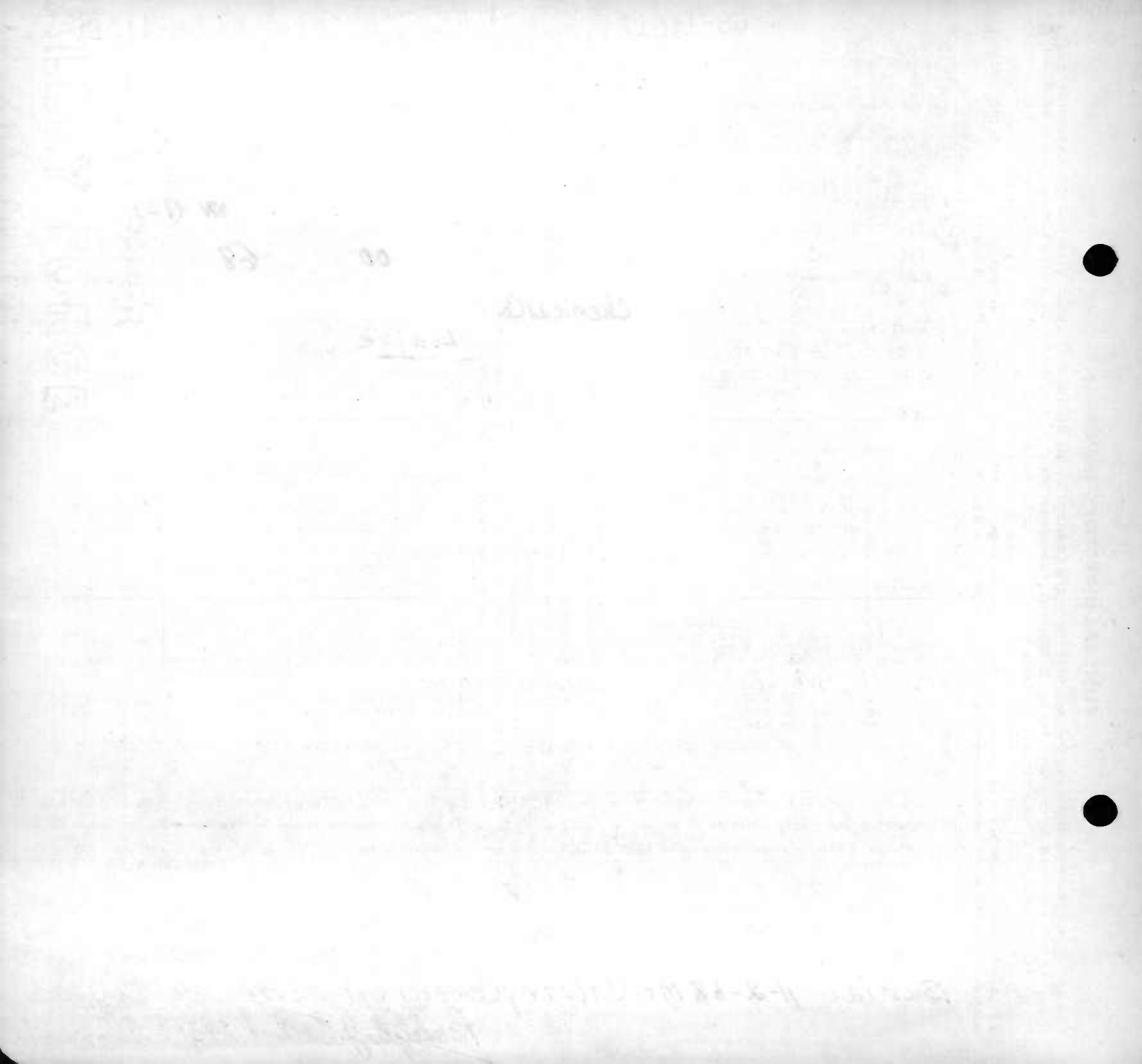
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11011 CERTIFICATE OF DEATH

REG. NO. 68-11011

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALSTON, MR HARRISON		2. DATE AND HOUR OF DEATH 10.30.68 1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <input checked="" type="checkbox"/> B. COUNTY <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL			C. CITY OR TOWN S-PS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1808 N. BOND ST (18) (13)					
5. SEX m	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9.10.00	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd Laborer Chemical Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOUIS ALSTON		14. MOTHER'S MAIDEN NAME LOUISE CHARA YOUNG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MARIAN GRINNAGE, 637 Barlett Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Obstructive uropathy			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 683X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 1 Oct 26, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostate cystoscopy + multilobular catheterization		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10.18.1968 to 10.30.1968 , that (I) (we) last saw the deceased alive on 10.30.1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE m. Dowla				23B. DATE SIGNED 10.30.68	
23C. PHYSICIAN'S NAME (Type) MESBAHUD - DOWLA MD.				23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) Anne Arundel Co. Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Rafael E. Johnson		25C. FUNERAL DIRECTOR Randolph J. Collick	
25D. ADDRESS 2431 E. Oliver St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11012 CERTIFICATE OF DEATH

REG. NO. 00-11111

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sessoms, Benjamin		2. DATE AND HOUR OF DEATH October 31, 1968 5:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-28-20		9. AGE (in years last birthday) 48		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Sessoms		14. MOTHER'S MAIDEN NAME Elnora M. Sessoms	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 240-09-3246		17. INFORMANT Mrs. Janet Winbush-daughter	
18. ADDRESS 2221 Montecello Road		19. CAUSE OF DEATH Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Paracetamol abuse, Pleurisy			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus			
(C) Diabetes Mellitus					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21G. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21H. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from October 23, 1968 to October 31, 1968 , that (I) (we) last saw the deceased alive on October 31, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Harold A. DeBorja		23B. DATE SIGNED 10-31-68	
23C. PHYSICIAN'S NAME (Type) HAROLD A. DE BORJA		23D. ADDRESS 1514 Division Street Balto., Maryland		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11.4.68		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Balto City		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Ludlow Carroll		25D. ADDRESS 15298 North Ave			

Sept 10 1891

Received of Mrs. J. H. Smith
the sum of \$10.00
for rent of room

James H. Smith

Witness my hand and seal
this 10th day of September 1891

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11013				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11013	
1. NAME OF DECEASED (Type or Print) SWINTON, Frank				2. DATE AND HOUR OF DEATH 10/31/68 1 8:39 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) J. H. H. THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 1807 M. GAY ST							
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/10/31	9. AGE (In years last birthday) 36	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK				14. MOTHER'S MAIDEN NAME HAMBURGERS BACKUS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 250-42-5703		17. INFORMANT YELLOW SHEET		ADDRESS	
18. CAUSE OF DEATH O.D. 431.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) INTRACRANIAL BLEED DUE TO (B) ARTERIOVENOUS ANEURYSM DUE TO (C) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/29 19 68 to 10/31 19 68, that (I) (we) last saw the deceased alive on 10/31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John M. Stabo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/31/68	
23C. PHYSICIAN'S NAME (Type) JOHN M. STABO				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/5/68		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. 11/1/68		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph J. Lock		ADDRESS 1304 N. Central Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11014	
68-11014 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RADTKE, MR. CHARLES M.		10-31-68 11 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
48 Maryland General Hospital			Maryland 27-07		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2911 Chesley Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M.	W.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-28-91	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MINER		MINING		PENNA.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HERMAN RADTKE			AMELIA EWART		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		171-01-3157 (Son)		ALBERT RADTKE 2911 CHESLEY AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
011.4 I			Respiratory arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Tuberculous pneumonia (C) military Tuberculosis		
002.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-16-1968 to 10-31-1968, that (I) (we) last saw the deceased alive on 10-31-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mohammad Sidig					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MOHAMMAD SIDIG		Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11/4/68	Mt. Laurel Mem. Park		Hazle Township, Luzerne Cty. Pa.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
NOV 1 1968	Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

BIRTH NO. 626		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11015	
M.E. CASE NO.		1. NAME OF DECEASED M. DOROTHY DOROTHY ORSER		2. DATE AND HOUR OF DEATH Oct 28, 1968 11:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 2-10-14		9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSERY TEACHER	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK J. DINGLE	
14. MOTHER'S MAIDEN NAME ROSE V. GIBBONS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 151 12 0432	
17. INFORMANT MR. ROBERT C. ORSER (husband)		ADDRESS SAME AS #4		18. CAUSE OF DEATH 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic adenocarcinoma of lung (A) DUE TO (B) Bronchiolar adenocarcinoma (C) DUE TO 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 165X II	
19A. DATE OF OPERATION 9/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pain (preportal biopsy)		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Aug 26 1968 to Oct 28 1968, that (I) (we) last saw the deceased alive on Oct 28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Lawrence J. Jelsma M.D.	
23B. DATE SIGNED Oct 28, 1968		23C. PHYSICIAN'S NAME (Typo) LAWRENCE JELSMA		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV. 1/68		24C. NAME of CEMETERY or CREMATORY GLEN HAVEN MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968		25B. NAME OF REGISTRAR Robert E. Jelsma	
25C. FUNERAL DIRECTOR R. J. Singleton		25D. ADDRESS SINGLETON FUNERAL HOME		25E. ADDRESS GLEN BURNIE, MARYLAND	

Marriage record of Robert Clifton Orser & M. Dorothy Dingle at St. Paul's Church,
New York City on May 4, 1934

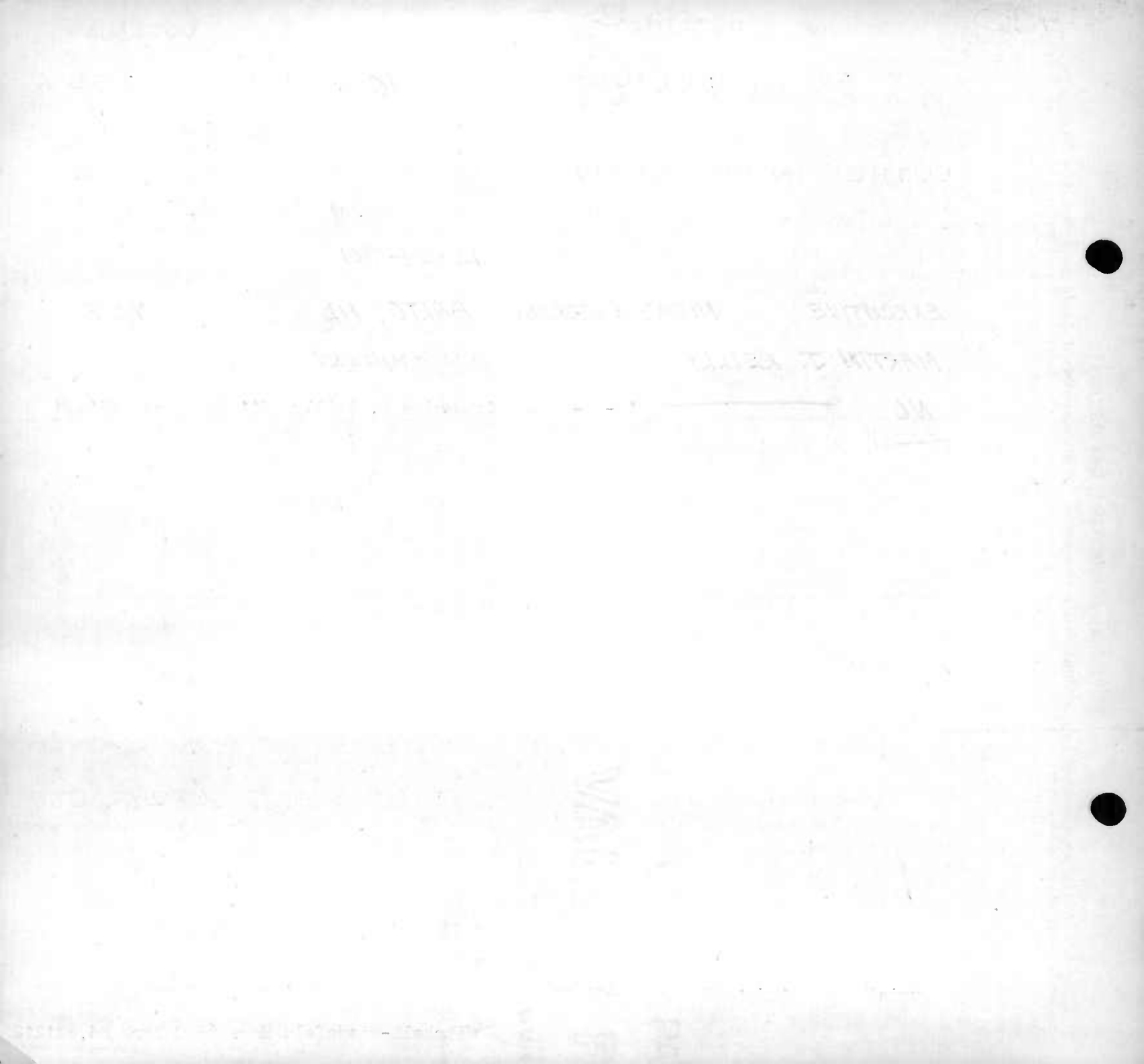
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11016 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. X

68-11016

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCIS H. REILLY		2. DATE AND HOUR OF DEATH 10-29-68 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSP. OF MD. 730 ASHBURTON ST. BALTIMORE, MD. 21216			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21204 53-00		
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE			E. STREET AND NUMBER 8011 YORK ROAD APT. C7		
10B. KIND OF BUSINESS OR INDUSTRY MOVING & STORAGE			8. DATE OF BIRTH 12-24-1901 9. AGE (In years lost birthday) 66		
11. BIRTHPLACE (State or foreign country) BALTO, MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MARTIN J. REILLY			14. MOTHER'S MAIDEN NAME JULIA M. HENRY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-03-7282A		
17. INFORMANT Katherine M. Reilly			ADDRESS 8011 York Road #21204		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY OEDEMA ACUTE MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INFARCTION		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(B) DUE TO, OR AS A CONSEQUENCE OF:		
21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 10-28-68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED removal embolus femoral & foot 20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) ---		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? ---		
22. I certify that (I) (this hospital) attended the deceased from 10-18-1968 to 10-29-1968 , that (I) (we) last saw the deceased alive on 10-29-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pratibha Joshi			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) PRATIBHA JOSHI			23D. ADDRESS LUTHERAN HOSP. OF MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/31/68		
24C. NAME OF CEMETERY OR CREMATORY Cathedral			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1968			25B. NAME OF REGISTRAR Robert E. Fickens		
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			ADDRESS 6500 York Rd. #21212		



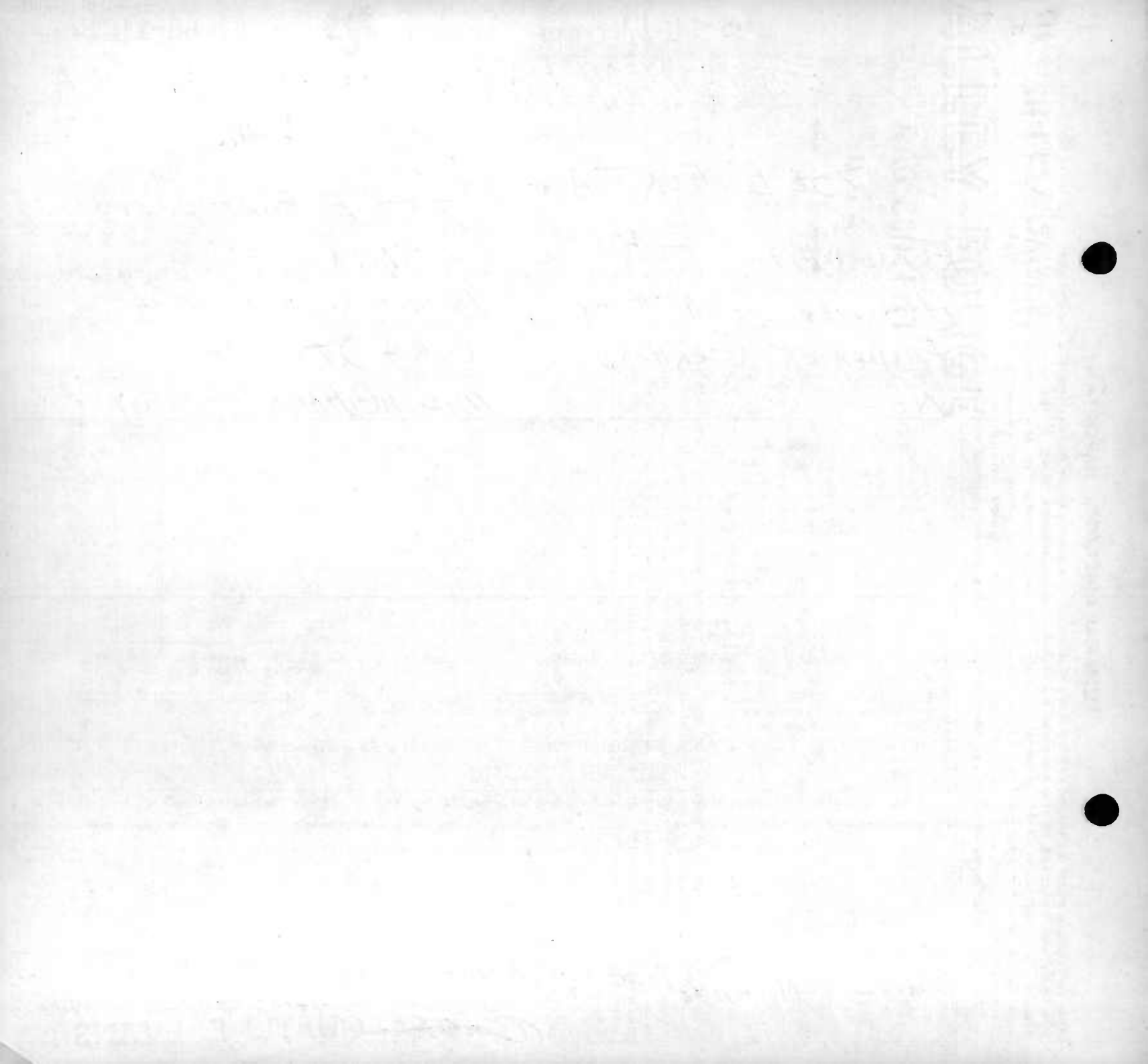
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11017 CERTIFICATE OF DEATH

REG. NO. 68-11017

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDNA MAY HARN		2. DATE AND HOUR OF DEATH Sat. Nov. 2 1968 4 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 24-02		
FULL NAME OF HOSPITAL OR INSTITUTION 756 E. FORT AVE.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		9. AGE (In years last birthday) 65
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FREDERICK GERHARD			14. MOTHER'S MAIDEN NAME DORA STUMPF		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -			16. SOCIAL SECURITY NO.		17. INFORMANT McLVING G. HARN (HUSBAND)
18. 470.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis			(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis		1 yr.
19. DATE OF OPERATION 420.1 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Oct. 28 1968 to Nov. 2 1968 , that (I) (we) last saw the deceased alive on 11-1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. C. SOLLLOD M.D.				23B. DATE SIGNED 11-1-68	
23C. PHYSICIAN'S NAME (Type) A. C. SOLLLOD M.D.				23D. ADDRESS 707 E. FORT AVE. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Nov. 5, 1968		24C. NAME OF CEMETERY OR CREMATORY Taylorville Mth. Church - Taylorville, Carroll Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR John A. B. Taylor		25C. FUNERAL DIRECTOR 1400 S. CHARLES ADDRESS 21230 CURTIS E. EVANS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11018

Baltimore City Health Department CERTIFICATE OF DEATH

REG. NO. X

68-11018

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Koehnlein John</u>		2. DATE AND HOUR OF DEATH <u>10/30/68 10:15a</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48 Linden Ave</u> <u>Baltimore, Maryland</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>♂</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B.O. Rail Road</u>		8. DATE OF BIRTH <u>10/12/98</u> 9. AGE (In years lost birthday) <u>70</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Frederick Koehnlein</u>	
14. MOTHER'S MAIDEN NAME <u>Sophia Rehling</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>70509411</u>	
17. INFORMANT <u>Wife</u>		ADDRESS <u>Same</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hemorrhage from stress Ulcers</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>2° Microglioma left frontal area</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12h</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>193.0 II</u>					
19A. DATE OF OPERATION <u>1/10/10/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain Tumor</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/25/68</u> 19 to <u>10/30/68</u> 19, that (I) (we) last saw the deceased alive on <u>10/30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.L.S. Brown, M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M.L.S. Brown, M.D.</u>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-2-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D. BY HEALTH DEPT. <u>NOV 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt</u>		25C. FUNERAL DIRECTOR <u>Harold H 7401 Belair Rd.</u>	

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11019
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Henry W. Schelhouse		Nov. 1, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 1801 S. Charles St.			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1801 S. Charles St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 18, 1926	42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Net Mender		Twine & Net Co.		Balto. Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Elmer Schelhouse			U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No					Family
					Same
18. 227X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Extreme Obesity DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
287X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/29/68 to 10/29/68 that (I) (we) lost saw the deceased alive on 10/29/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Lozada				23B. DATE SIGNED 11/1/68	
23C. PHYSICIAN'S NAME (Type) RICHARDO LOZADA				23D. ADDRESS 1228 S. Charles St. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/1/68		Glen Haven	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Glen Burnie, Md Mc Cully 130 E. Fort Av	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		68-11020		68-11020	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>HEWITT, ELLA.</i>		2. DATE AND HOUR OF DEATH <i>11-1-68 4⁰⁰ A.</i>	
3. PLACE OF DEATH IN BALTIMORE MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>5300</i> D. STREET ADDRESS (If rural, give location) <i>7922 N. 32ND STREET</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>					
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>6-22-83</i>	9. AGE (In years lost birthday) <i>85</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JAMES PRICE</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-22-1531</i>		17. INFORMANT <i>WM. HEWITT</i> ADDRESS <i>7921 E. 33RD ST</i>	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>HASCVD</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>6-10 years</i>	
19. DATE OF OPERATION <i>11/1/68</i>		20. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/1/68 4:50AM</i> to <i>11/1/68 4:50AM</i> and that (I) (we) last saw the deceased alive on <i>11/1/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kevin Hennessey MD</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>11/1/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kevin N. Hennessey</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/4/68</i>		24C. NAME of CEMETERY or CREMATORY <i>GARDENS OF FAITH</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 4 1968</i>		25B. NAME OF REGISTRAR <i>John E. Hennessey</i>		25C. FUNERAL DIRECTOR <i>J. J. CONNELLY SONS</i> ADDRESS <i>300 MACE</i>	

John Howard

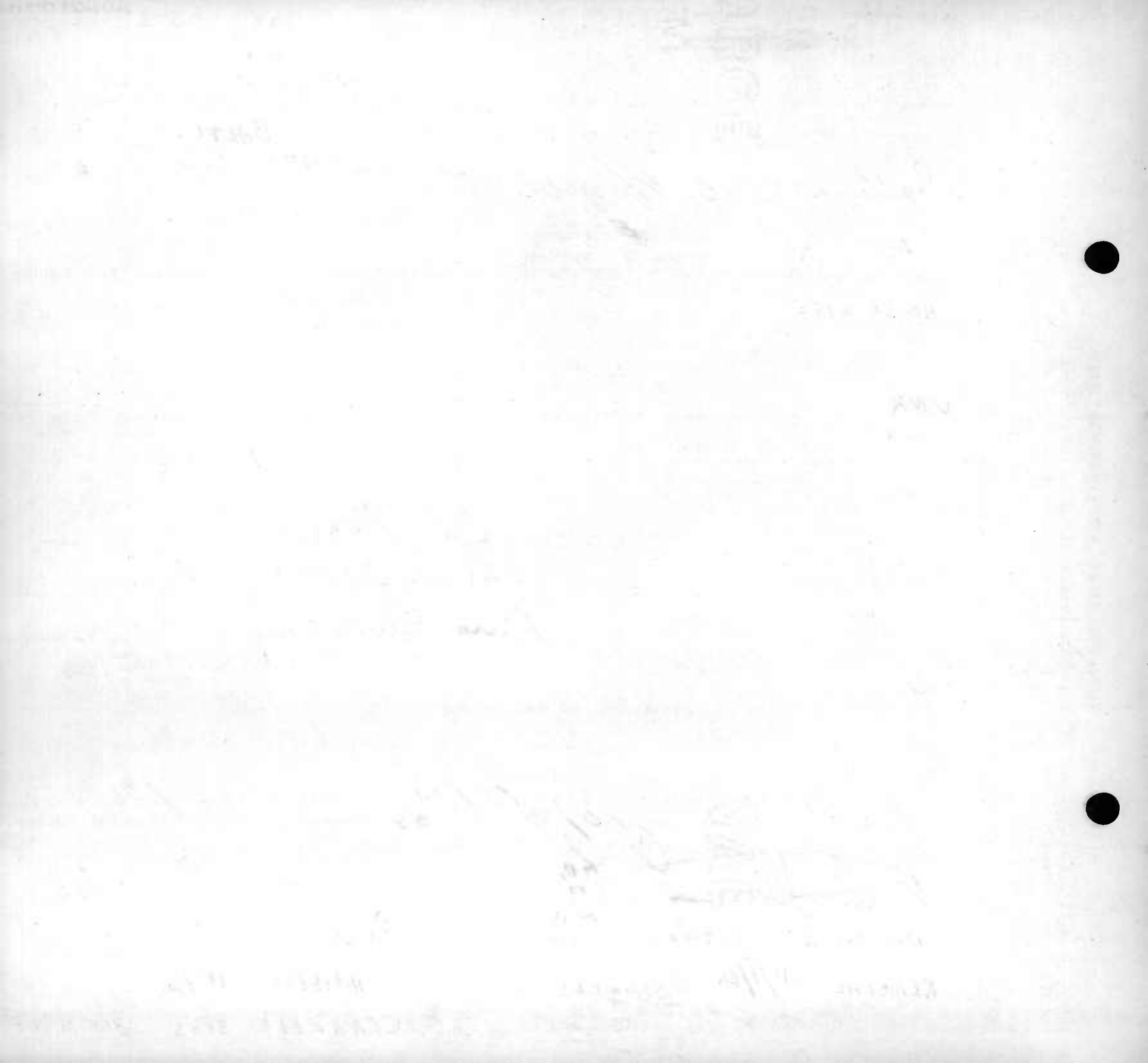
CERTIFICATE OF DEATH

REG. NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

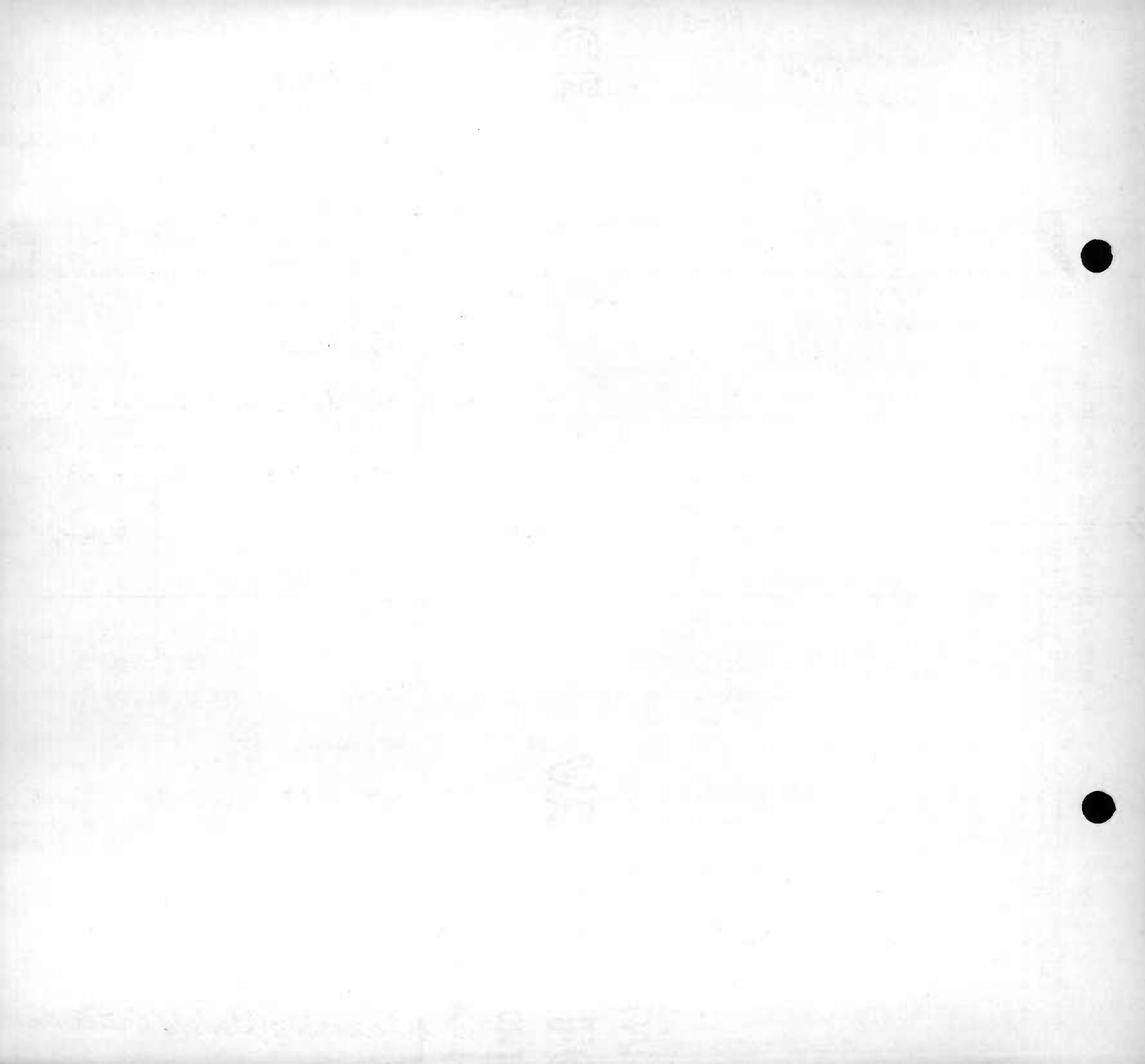
BIRTH NO.		1. NAME OF DECEASED (Type in Print) PANSY MAXWELL		2. DATE AND HOUR OF DEATH 10/31/68 13:44 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 EASTERN AVE. BALTO. MD. 21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2-14-10 9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SHOEMAKER				14. MOTHER'S MAIDEN NAME ROSA LEE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO.	
17. INFORMANT BCH: 4940 EASTERN AVE. BALTIMORE, MD. #21224				ADDRESS	
18. 519.2 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF:					
(B) CO₂ Narcosis DUE TO, OR AS A CONSEQUENCE OF:					
(C) Chemical OPD + Cor Pulmonale					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) 527.2 II Atrial Fibrillation					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/21 1968 to 10/31 1968 , that (I) (we) last saw the deceased alive on 10/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Owen S. Surman M.D., C.M. DEGREE				23B. DATE SIGNED 10/31/68	
23C. PHYSICIAN'S NAME (Type) DR. Owen S. SURMAN M.D., C.M. DEGREE				23D. ADDRESS 4940 EASTERN AVE. BALTIMORE, MD. Baltimore City Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 11/1/68		24C. NAME OF CEMETERY or CREMATORY SOMMERS	
24D. LOCATION (City, town, or county) HALLECK W. VA.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. ED CONNELLY SONS	
25D. ADDRESS 300 MALE					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11022	
BIRTH NO. 66-20978		68-11022		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Sherry Lee Hodiste</u>			2. DATE AND HOUR OF DEATH <u>10/30/68</u> <u>7:25 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u> <u>422</u>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-08</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1422 Redfern Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/66</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Joseph W. Hodiste</u>			14. MOTHER'S MAIDEN NAME <u>Sandra J. Neal</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>JOSEPH W. HODISTE</u> ADDRESS <u>1422 REDFERN AVE</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary obstruction</u> (B) <u>Pulmonary Cancer</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u> <u>3 mo.</u>
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>10/30</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>0</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>September 19 68</u> to <u>10/30</u> 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>10/30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas C. Washburn, M.D.</u> DEGREE				23B. DATE SIGNED <u>10/30/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas C. Washburn, M.D.</u> DEGREE				23D. ADDRESS <u>222 W. Cold Spring Lane</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/2/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loraine Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1968</u>		25B. NAME OF REGISTRAR <u>Paul E. Chasnowitz</u>		25C. FUNERAL DIRECTOR <u>Paul E. Chasnowitz</u> ADDRESS <u>3615 Chestnut Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

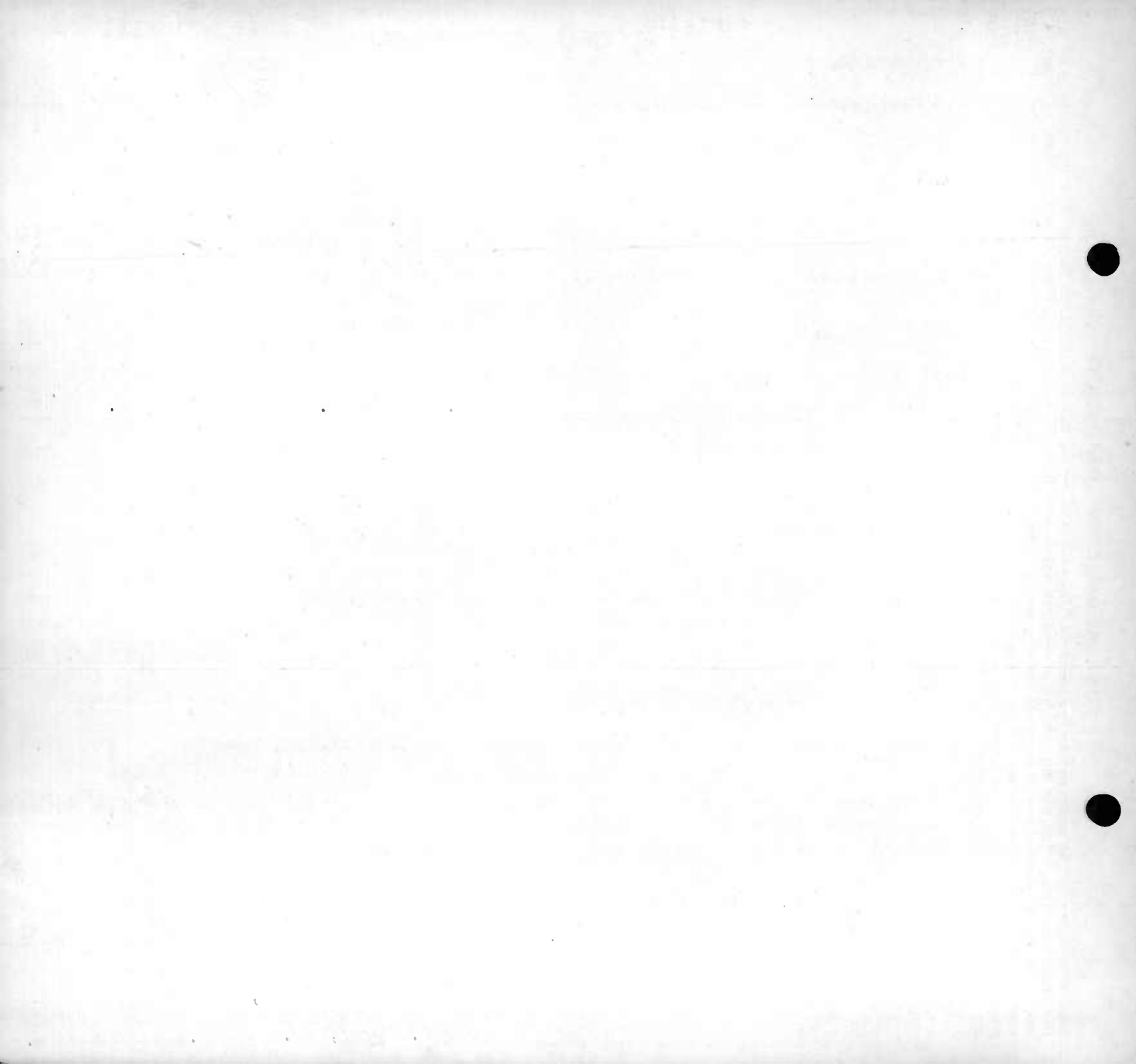
68-11023

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11023

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John A. Welzenbach</i>		2. DATE AND HOUR OF DEATH <i>10/31/68 8 PM M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>6-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>105 N. Decker Avenue</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/15/1888</i>	9. AGE (In years last birthday) <i>80</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Chauffeur Eastern</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Box factory</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Welzenbach</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Kutzdrenker</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>272078653</i>		17. INFORMANT <i>Mrs. Lillian A. Welzenbach</i>	
				ADDRESS <i>105 N. Decker Ave</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(B) <i>W. S. C. V. D.</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-28</i> 19 <i>68</i> to <i>10/31</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miguel Angel Mejia</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Miguel Angel Mejia</i>				23D. ADDRESS <i>M. G. H.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/4/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 4 1968</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11024

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11024

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Leona V. Einschutz</i>		2. DATE AND HOUR OF DEATH <i>November 1, 1968</i> <i>2:30</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>35 Church Home & Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2920 E. Pratt Street</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/21/'94</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Frederick Strauss</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Nichum</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Mrs. Eleanor Griffith</i> ADDRESS <i>2920 E. Pratt St</i>	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instantaneous</i>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i>					
(B) <i>Arteriosclerotic C. V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>10 yrs</i>					
(C) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Unknown</i>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 16</i> 19 <i>51</i> to <i>11/1</i> 19 <i>68</i> , that (I) was lost saw the deceased alive on <i>10/9</i> 19 <i>68</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE <i>Henry J. Houska</i>				23B. DATE SIGNED <i>11/2/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>HENRY J. HOUSKA M.D.</i>				23D. ADDRESS <i>333 S. EAST AVE BALTO MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/4/'68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11025
BIRTH NO.		68-11025 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ETHIER George E.		11-1-68 1.30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
Union Memorial Hospital 332d & Calvert.		M.D. Baltimore		
		C. CITY OR TOWN. D. INSIDE CITY LIMITS?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
		Frederick Ave 1923		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-29-11	56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Self employee of Food, Dispen.		Canada		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
LOE Ethier		Unknown.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
NO NONE		218-42-8455		M. Habashi M.D. Union Mem. Hospital
18. CAUSE OF DEATH		ADDRESS		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		Hepatic coma		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Disseminated Ca of Prostate		
		(C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
10-24-68 cholecystitis - Ca discovered				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 10-04 1968 to 10-31 1968, that (I) (we) last saw the deceased alive on 10-31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
M. Habashi M.D.				11-1-68
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Maher F. Habashi M.D.		Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
BURIAL	Nov. 4, 1968	NEW CATHEDRAL	BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
NOV 4 1968	James H. Miller	2101 Frederick Ave		

10-2-58

10-2-58

10-2-58

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10-2-58

10-2-58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11026

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARL LINEBERGER

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
10 29 68 8:50p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

D.O.A.

Franklin Square Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
October 29, 1968 8:50 pm

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒ NO ☐

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

May 24, 1900

10. AGE (In years lost birthday)

68

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1200 W. Lexington St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Barry Lineberger

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

Unknown

15. MOTHER'S MAIDEN NAME

Martha Ferris

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

17. SOCIAL SECURITY NO.

Unk

18. INFORMANT

Brady Lineberger Washington, D.C. 1001

ADDRESS

1019 8th Street, N.W.

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Asthma
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-6-68

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore Co, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1968

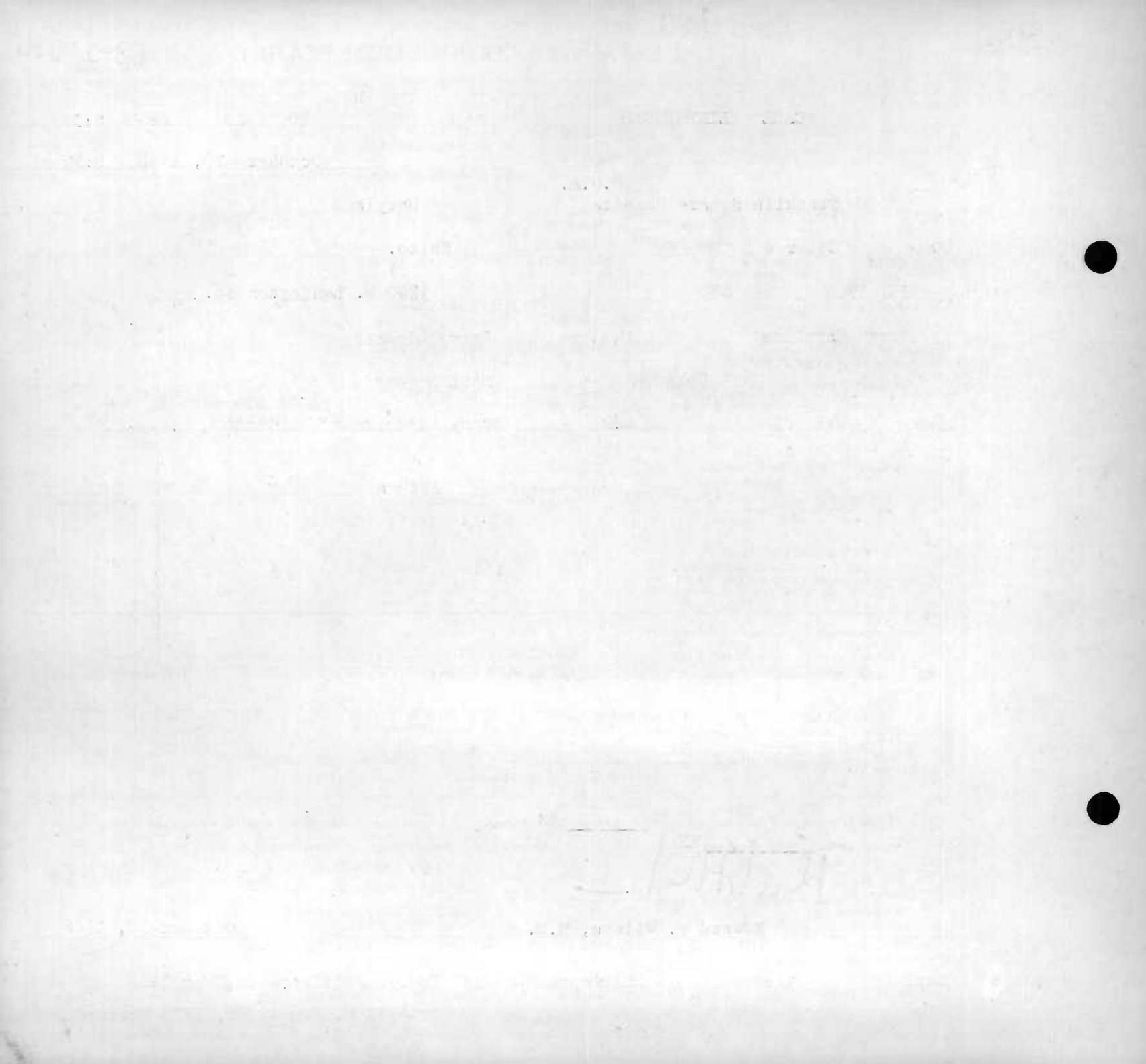
25B. NAME OF REGISTRAR

Robert E. Fagbema

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. 1735 Harford

ADDRESS



D-132

68-11027 BALTIMORE CITY HEALTH DEPARTMENT

68-11027

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

OTIS BRUCE DAVIDSON DAVIS

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 1, 1968

5:30 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 1, 1968

5:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

6-30-1914

10. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

517 N. Arlington Avenue

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James Davidson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hattie Anderson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

213-18-7057

18. INFORMANT

ADDRESS

Esther Davidson 3519 Reisterstown Road

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fatty Alteration of Liver

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Bilateral Bronchopneumonia

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6 Nov 68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1968

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. 1735 Harford Av

ADDRESS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11028

BIRTH NO.

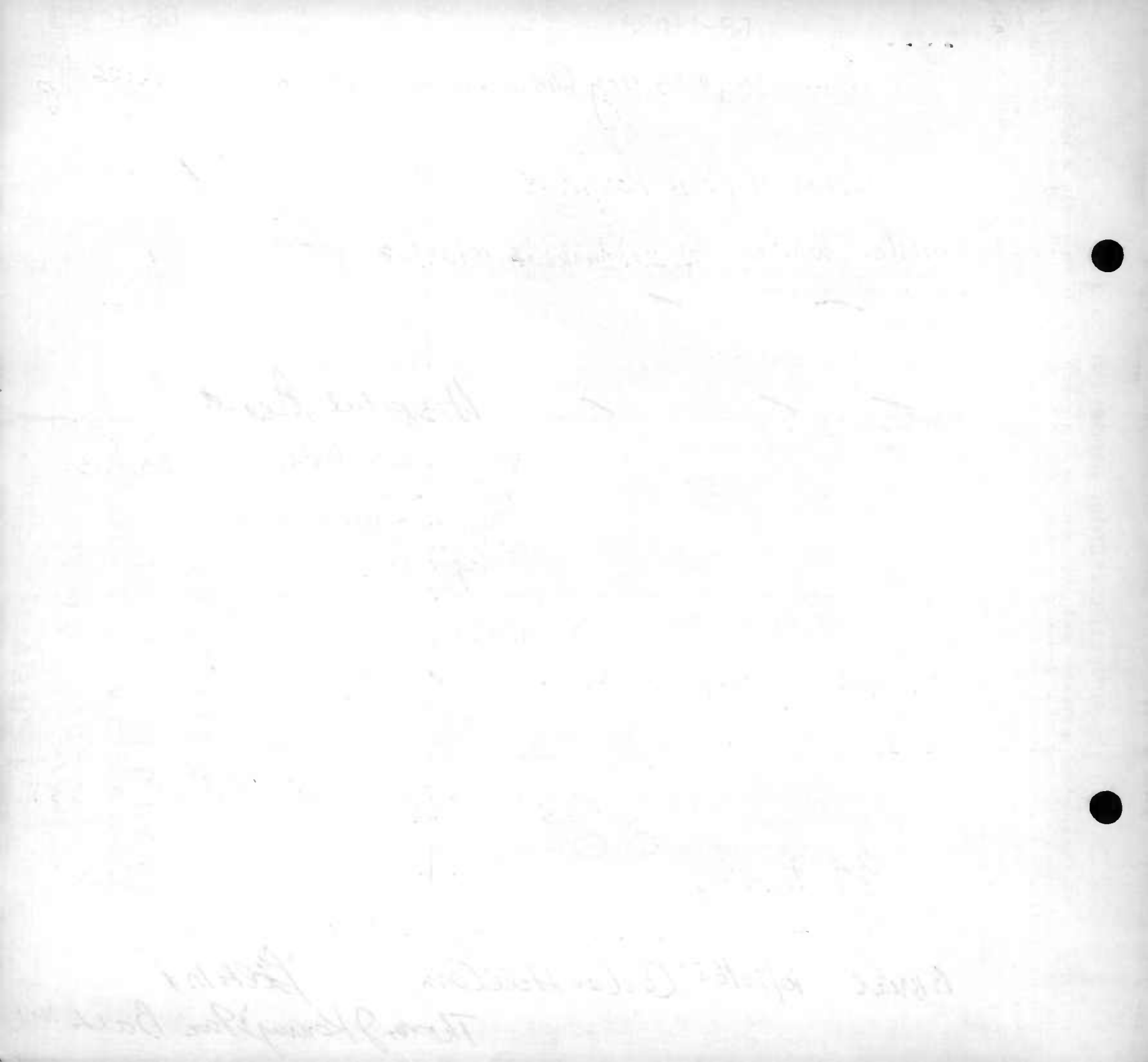
1. NAME OF DECEASED (Type or Print) PLEAS NOLAN JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 1, 1968		Hour 11:00 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968		Hour 11:00 A.M.
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
9. DATE OF BIRTH 8-8-36	10. AGE (In years lost birthday) 32	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1432 N. Central Avenue
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NOLAN PLEAS, SR.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Labor		15. MOTHER'S MAIDEN NAME Beulah Thomas
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-30-0727		18. INFORMANT Ruth Brown ADDRESS 1432 N. Central Ave.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Stab wound of Abdomen complicated by Peritonitis and bronchopneumonia (A) IMMEDIATE CAUSE XXXXXX (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E982X II				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street ??		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 800 E. Eager Street
22D. TIME OF INJURY (APPROX.) June 30, 1968 ?? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED November 1, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. ADDRESS 1735 Harford		

WALLING & COMPANY
LONDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

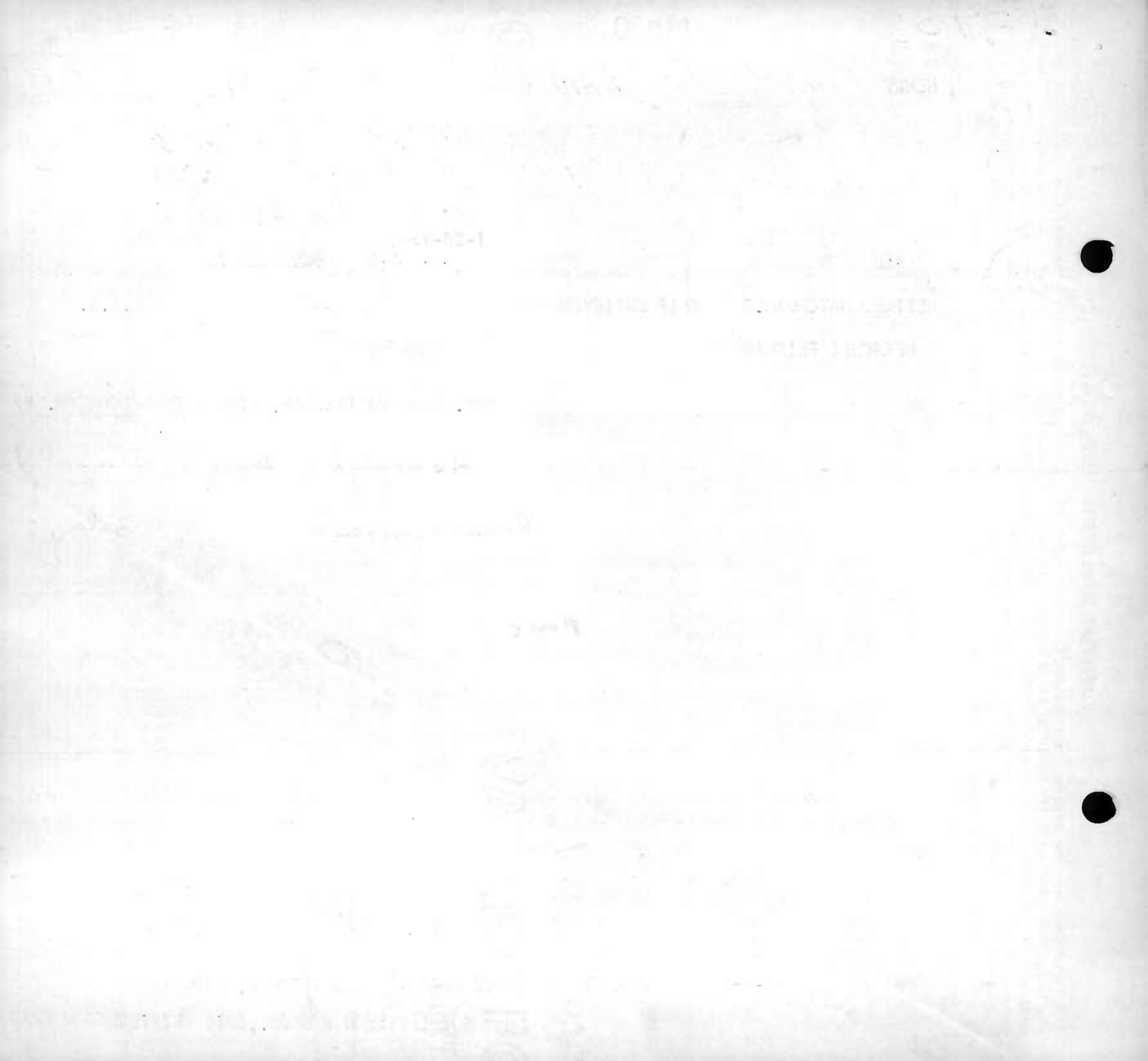
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 68-11029	
BIRTH NO. 68-11029											
M.E. CASE NO. <i>Baltimore Co. Md.</i>											
1. NAME OF DECEASED (Type or Print) <i>Ashbrook, baby boy Charles Edward</i>					2. DATE AND HOUR OF DEATH <i>10/28/68 12:26 P.M.</i>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>						
					D. STREET ADDRESS (If rural, give location) <i>1606 Hollins St.</i>						
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>		8. DATE OF BIRTH <i>10/27/68</i>	9. AGE (In years last birthday) <i>1</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William Ashbrook</i>					14. MOTHER'S MAIDEN NAME <i>Jeannie Lynn</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>			ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>5-51-1</i>					CAUSE OF DEATH (A) DUE TO <i>respiratory distress syndrome</i> (B) DUE TO <i>hyaline membrane</i> (C) <i>or Aspiration</i>					INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>540.2 II omphalocele</i>											
19A. DATE OF OPERATION <i>10/27/68</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>omphalocele</i>		20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 27</i> 19 <i>68</i> to <i>Oct 28</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct 28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Peter Nissley</i>					M.D. Attending Phys. <input type="checkbox"/> Resident <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>10/28/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Peter Nissley, M.D.</i>					23D. ADDRESS <i>The Johns Hopkins Hospital</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>10/30/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cem</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>			
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 4 1968</i>			25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>			25C. FUNERAL DIRECTOR <i>Thomas J. Kennedy Inc</i>			ADDRESS <i>Baltimore Md</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11030
BIRTH NO. 35		68-11030		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) HENRY FRANK Feldman		2. DATE AND HOUR OF DEATH 30 Oct 1968 6 15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore 42		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND , B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4107 MAINE AVE 21215		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-93	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WATCHMAKER		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) Latvia
13. FATHER'S NAME HERSCHEL FELDMAN		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. REBECCA FELDMAN, 6736 D TOWNBROOK DR. #7
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction, Massive (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 days
19A. DATE OF OPERATION 493X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from 29 Oct 1968 to 30 Oct 1968 , that it (we) lost saw the deceased alive on 30 Oct 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) not view the body after death.				
23A. SIGNATURE Morris Ostroff, M.D.		23B. DATE SIGNED 30 Oct 1968		23C. PHYSICIAN'S NAME (Type) Morris Ostroff, M.D.
23D. ADDRESS Sinai Hospital of Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 11-1-68		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH (AITZ CHAIM)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR SOL LEVINSON & BROS.		25C. FUNERAL DIRECTOR ADDRESS 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11031

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

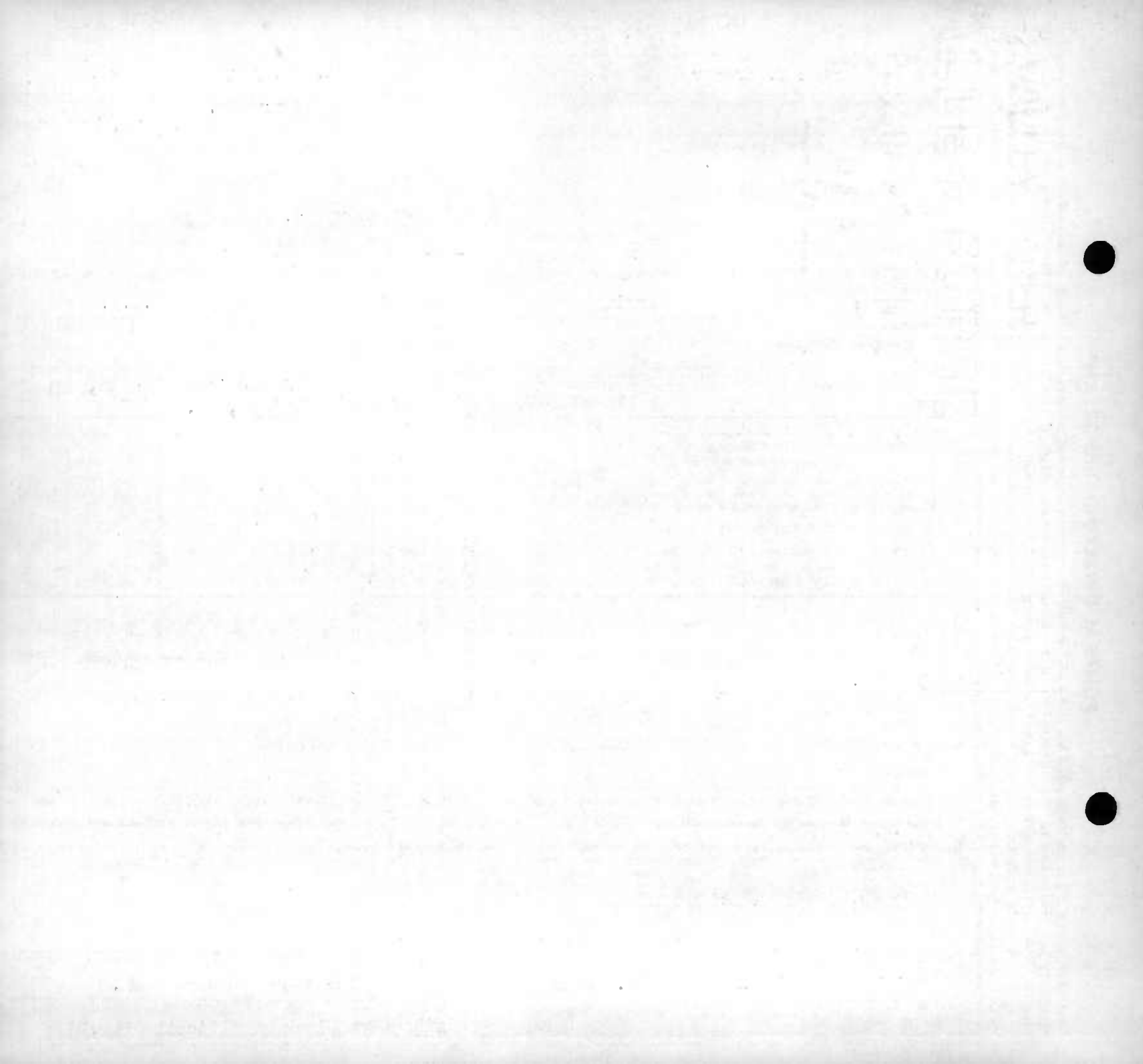
68-11031

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LARRY Jones		2. DATE AND HOUR OF DEATH 10/31/68 3:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-D	
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 607 Pennsylvania Ave.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Amer. Negro.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY ?		8. DATE OF BIRTH 2/12/1875 9. AGE (In years last birthday) 93	
13. FATHER'S NAME Mace Jones		14. MOTHER'S MAIDEN NAME FANNIE GARDNER		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 56-3375		17. INFORMANT Chart ADDRESS 607 Pennsylvania Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 + 250.9 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Arterioscler. Heart Disease		Unknown	
		(C) Gen. arteriosclerosis		Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		Double A-K Amputee		Unknown	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/26 19 63 to 10/31 19 68 , that (I) (we) last saw the deceased alive on 10/15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. E. Holt				23B. DATE SIGNED 10/31/68	
23C. PHYSICIAN'S NAME (Type) E. E. Holt, M.D.		23D. ADDRESS 3715 Liberty Heights Ave., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-2-68		24C. NAME of CEMETERY or CREMATORY MT CALVARY	
24D. LOCATION (City, town, or county) (State) CEDER HILL - C.G. COUNTY MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Robert E. Tabbara		25C. FUNERAL DIRECTOR Joseph Knight Funeral Home ADDRESS 1639 N. Broadway			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

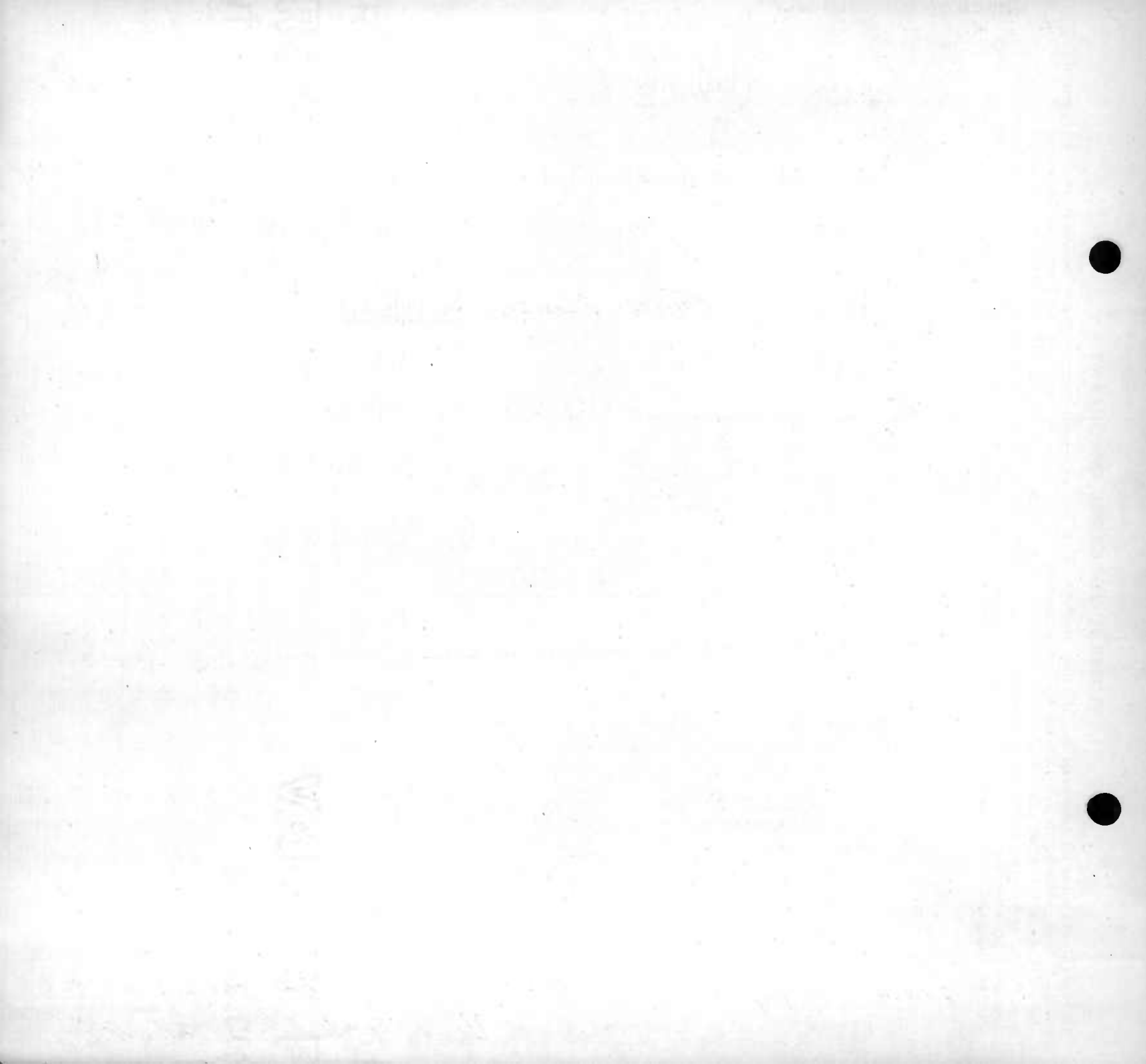
BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO.
68-11032				68-11032	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Herman H. Kramer	
2. DATE AND HOUR OF DEATH Oct. 29, 1968				5:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Howard Co. 211 Montgomery Rd. Ellicott City, Maryland	
				C. CITY OR TOWN Ellicott City	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 211 Montgomery Rd. 63-00	
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-87	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman Kramer		14. MOTHER'S MAIDEN NAME Mary Geisen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216 28 2962		17. INFORMANT ADDRESS 6504 Old Hunt Club Rd, Julia Sablowski Elkridge, Md. 21227	
18. 410.9 & 1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular Fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Acute Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Advanced ASCVD Diabetes -					
19A. DATE OF OPERATION 0 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Leg - Gangrene left		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-29-68 to 10-29-68, that (I) (we) last saw the deceased alive on 10-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alejandro Lopez				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MORA MD				23D. ADDRESS ST. Agnes Hospital - caton + wilkes AV.	
24A. BURIAL CREMATION REMOVAL (Specify) burial		24B. DATE 11/2/68		24C. NAME OF CEMETERY OR CREMATORY St. Marys	
24D. LOCATION Ilchester		24E. HOWARD		24F. MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Robert J. Sablowski		25C. FUNERAL DIRECTOR ADDRESS Higinbotham Slack Ellicott City, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-11033
1. NAME OF DECEASED (Type or Print) Carroll Mullinix			2. DATE AND HOUR OF DEATH 10-29-68 1:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hospital			A. STATE Md. B. COUNTY Howard Co. 63-00		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER Tri delphia Rd. Md. 21043		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-03-06	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY RETIRED FARMER		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Mullinix		14. MOTHER'S MAIDEN NAME Auralia Spert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-34-4078		17. INFORMANT Mary Mullinix	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarct		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus		(B) DUE TO, OR AS A CONSEQUENCE OF: Uremia	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-14-1968 to 10-29-1968 , that (I) (we) lost saw the deceased alive on 10-29-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Delfa E. Long, Ch.D.				23B. DATE SIGNED 10-29-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/31/68		24C. NAME of CEMETERY or CREMATORY MT VIEW	
24D. LOCATION (City, town, or county) (State) Alpha, Howard Co Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. SIGNATURE	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68-11034
BIRTH NO. 68-20807		68-11034 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARK		2. DATE AND HOUR OF DEATH BABY GIRL Michelle R. OCT. 31, 1968 5:40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP. OF MARYLAND		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ADDRESS OR LOCATION 730 ASHBURTON ST.		E. STREET AND NUMBER 127 TWIN CIRCLE			
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31, 1968	9. AGE (In years last birthday) 11 HRS	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 11
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALBERT M. Clark		14. MOTHER'S MAIDEN NAME ROSALIE Buckheit			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Albert M. Clark	
				ADDRESS 127 Twin Circle 27	
18. 777 X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE PREMATURITY DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
19. 776 X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) OCT. 31 1968 5:40 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 31 1968 to OCT. 31 1968 , that (I) (we) last saw the deceased alive on OCT. 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vilma F. Tadalan MD		23B. DATE SIGNED OCT. 31, 1968		23C. PHYSICIAN'S NAME (Type) Vilma F. Tadalan	
		23D. ADDRESS Glen Haven		23E. FUNERAL DIRECTOR McKully	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 1 68		24C. NAME of CEMETERY or CREMATORY Glen Burnie, A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR John E. Tadalan		25C. FUNERAL DIRECTOR 130 E. Fort Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

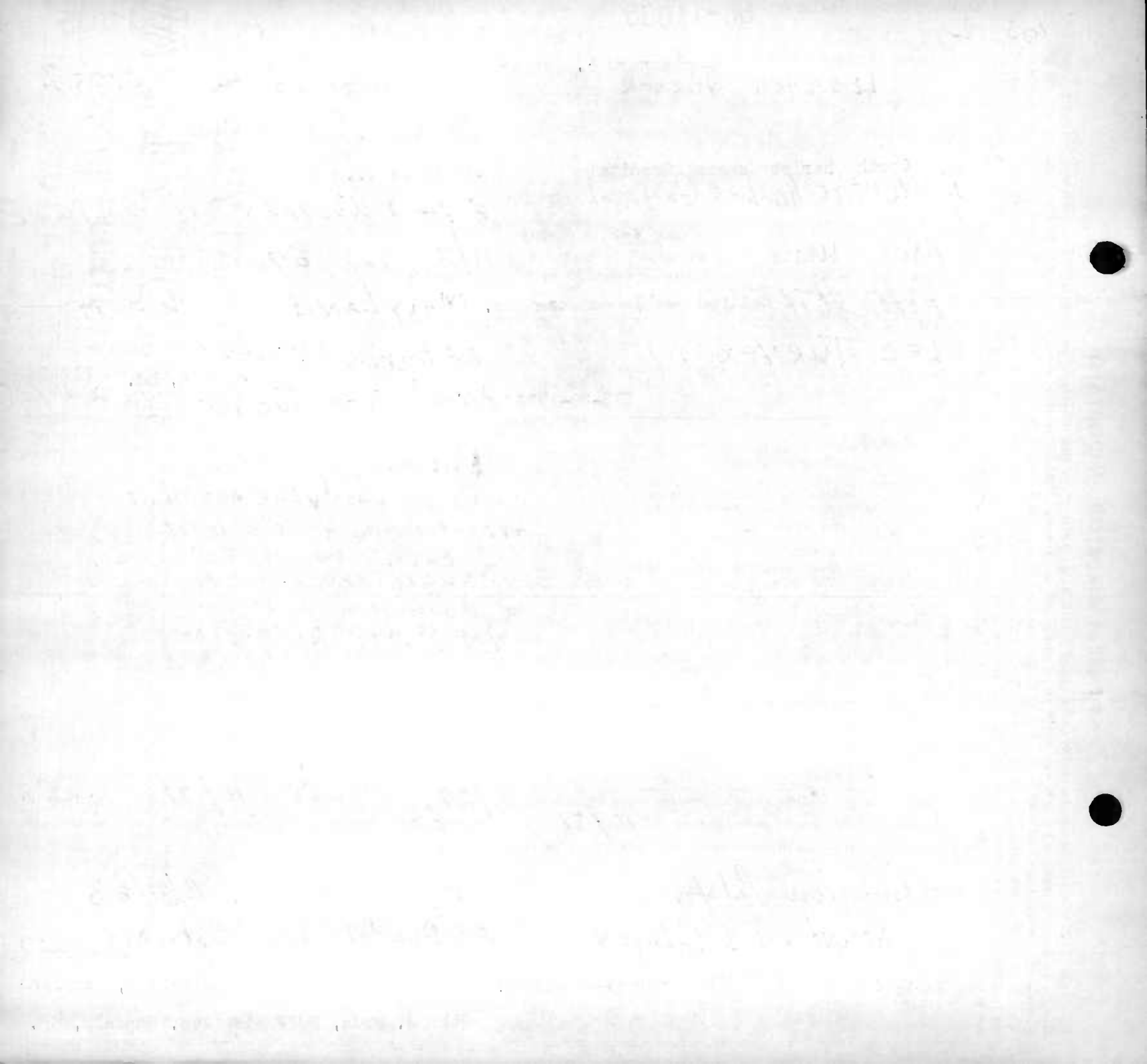
68-11035

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11035

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LEONARD TURNER Leonard F. Turner		2. DATE AND HOUR OF DEATH 10/31/68 10:23 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles General Hospital 49 North Charles General Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. 53-00 C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6742 Woodley Rd. Balto.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1900 67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth. Steel		10B. KIND OF BUSINESS OR INDUSTRY Retired Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Lee TURNER (D)			
14. MOTHER'S MAIDEN NAME Katherine MOONEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-09-1335		17. INFORMANT (Name and Address) Wife) Dundalk, Md. ADDRESS 21222 ANASTASIA TURNER 6742 Woodley Rd			
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA = CEREBROVASCULAR ACCIDENT = HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE = CONGESTIVE HEART FAILURE = PNEUMONIA = SEVERE HYPERTENSION = HE PATEMUS SALLY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 443 X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/29 1968 to 10/31 1968 , that (I) (we) last saw the deceased alive on 10/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Asuncion Palafox				23B. DATE SIGNED 10/31/68	
23C. PHYSICIAN'S NAME (Type) ASUNCION L. PALAFOX				23D. ADDRESS 33 Dundalk Ave Balto. Md. 21222	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/68		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 68-11036		68-11036 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RUTH KURTZ			2. DATE AND HOUR OF DEATH 11-2-68 6:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49 NORTH CHARLES GEN HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY A.A. Co C. CITY OR TOWN N. Linthicum D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8 PATAPSCO ROAD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/91		9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John TRACY			14. MOTHER'S MAIDEN NAME SARAH BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Family Same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 252.1 I Cardiovascular Collapse 20		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Thyrotoxicosis with atrricular fibrillation - Toxic Nodule left lobe thyroid gland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH stat	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: chole docholithiasis - obstruction		Since 10/8/68	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 252.1 II Ascending cholangitis + Hepatitis		D-Advanced Paget's Disease		Years	
19A. DATE OF OPERATION 10/31/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chole docholithiasis		20A. AUTOPSY? (Yes or No) Denied	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from late 9/26 August 1968 to 11/2 19 68 , that (I) (we) last saw the deceased alive on 11/2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard Flax M.D.				23B. DATE SIGNED 11/2/68	
23C. PHYSICIAN'S NAME (Type) LEONARD FLAX M.D.		23D. ADDRESS NORTH CHARLES GEN. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/5/68	24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR John E. Jackson		25C. FUNERAL DIRECTOR ADDRESS McCully Funeral Home	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11037 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11037	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Christina R. Sauerbrey		2. DATE AND HOUR OF DEATH 10/30/68 7 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY Baltimore Co.		
FULL NAME OF HOSPITAL OR INSTITUTION Gould Convalescent Home			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4719 Ridge Rd.					
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 21, 1890	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Baltimore County	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME OTTO Seifert			
14. MOTHER'S MAIDEN NAME MARGARET Milchling		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT KARL SAUERBREY			
ADDRESS 8330 Belair Rd. Baltimore MD.					
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: massive sudden			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). upper respiratory tract infection			5 days		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/30 19 68 to 10/30 19 68 , that (I) (was) last saw the deceased alive on 10/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Paul G. Mueller M.D.				23B. DATE SIGNED 10/30/68	
23C. PHYSICIAN'S NAME (Type) PAUL G. MUELLER M.D.				23D. ADDRESS 6411 BELAIR RD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/2/68		24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	
24D. LOCATION (City, town, or county) (State) Baltimore MD.					
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Paul G. Mueller		25C. FUNERAL DIRECTOR LASSON FUNERAL HOME	
ADDRESS 7401 Belair Rd. Balt. MD.					

78

Topographical Information
Reference Section

Antennae Section
Reference Section

Upper respiratory tract infection

Paul G. Mueller M.D. 411 BELAIR RD.
X M.D. 411 BELAIR RD.
10/30/88

10/30/88

10/30/88

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

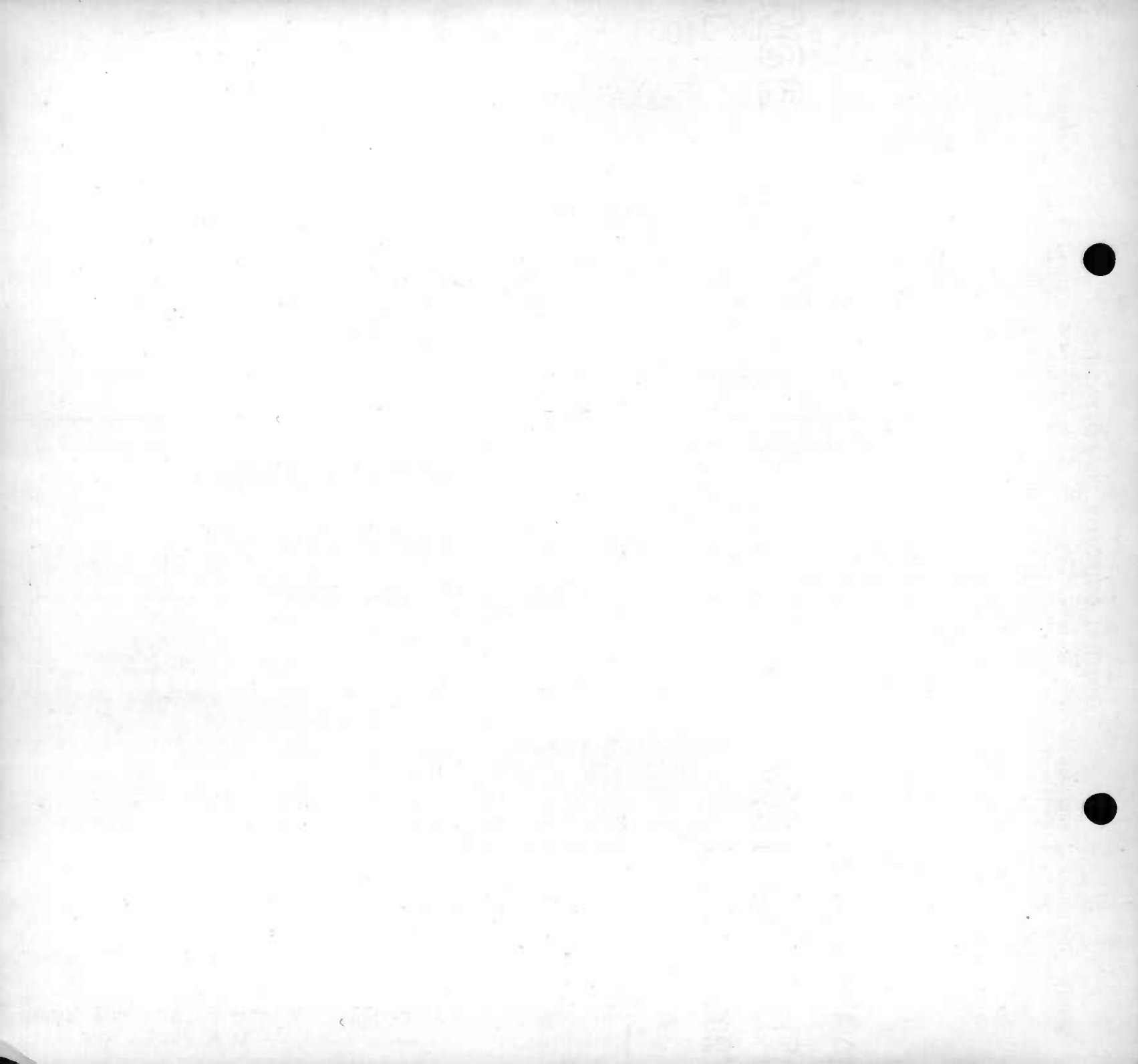
68-11038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11038

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George Jones		11-3-68 - 8:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
46 Lutheran Hospital of Maryland				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				320 N. Franklinton Rd	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday)
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			71 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Navassa North Caro. U S A	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes W W I		225-10-2922		Mr Leo Hughes, Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
148X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11-6-68		Caesarean		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-2-1968 to 11-3-1968, that (I) (we) last saw the deceased alive on 11-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
JH Baig				11-3-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR Roque / Baig					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/6/68		National Cemetery	
				Baltimore Md	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
11-6-68		Robert E. Taylor		I Carroll, Halstead Funeral Home 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

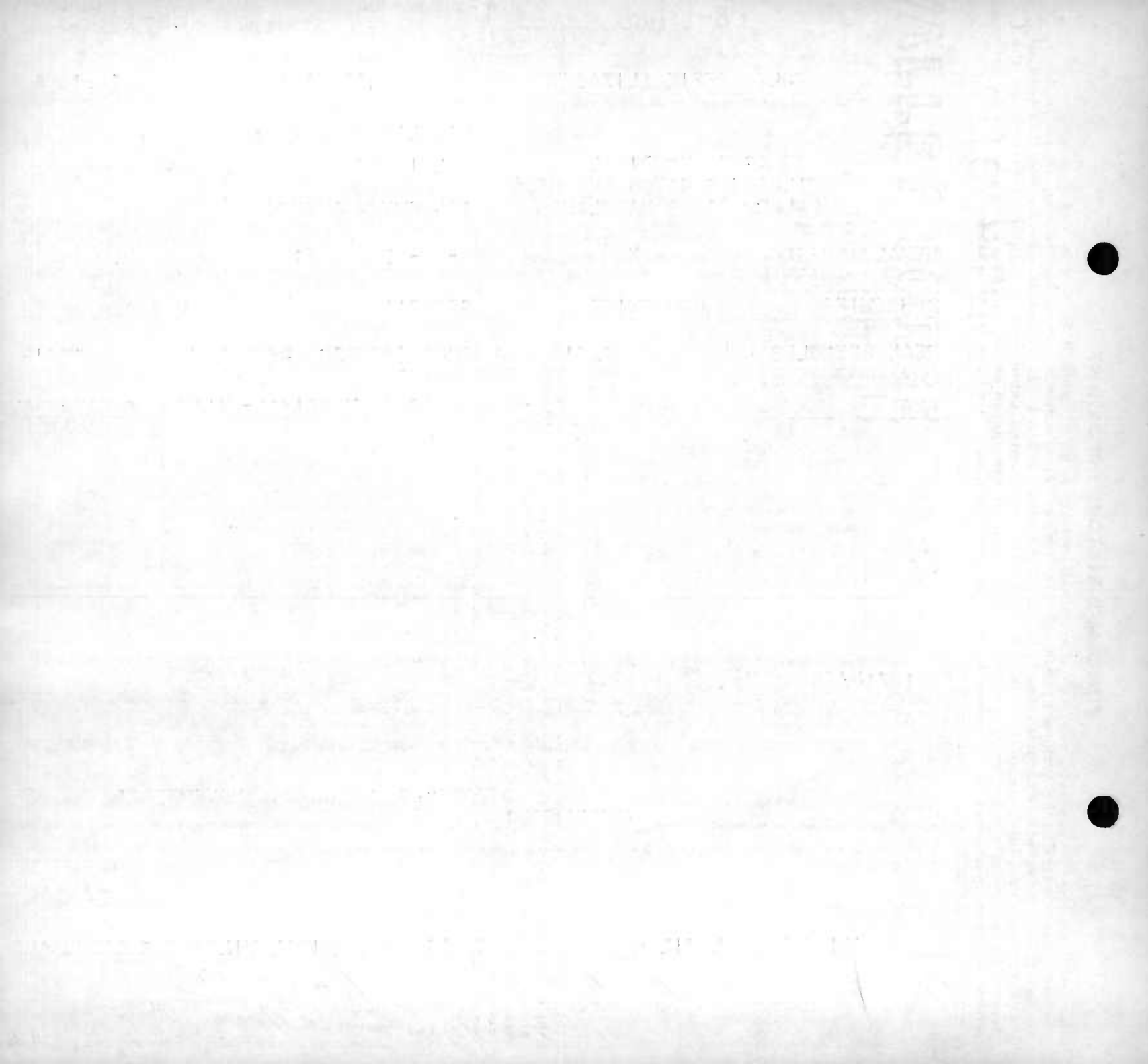
68-11039

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11039

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		COLE, EFFIE ELIZABETH		11 01 68 10:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 21229 MARYLAND			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 334 GWYNN AVENUE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-26-07	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) GEORGIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NEAL REYNOLDS DEC'D		14. MOTHER'S MAIDEN NAME EMMA (PENDER) REYNOLDS DEC'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2-16-22-4926		17. INFORMANT ST. AGNES HOSPITAL-WILKENS & CATON AVE	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH septicemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: peritonitis & wound abscess (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		carcinomatosis.			
19A. DATE OF OPERATION 3 10/14/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction.		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from OCTOBER 9, 19 68 to NOVEMBER 1, 19 68, that (I) (we) last saw the deceased alive on NOVEMBER 1, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jaime V. del Pilar		23B. DATE SIGNED 11/1/68		23C. PHYSICIAN'S NAME (Type) JAIME V. DEL PILAR	
23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVE.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/5/68		24C. NAME of CEMETERY or CREMATORY Mt AVALON		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR R. S. Talbot		25C. FUNERAL DIRECTOR M. J. Hays	
25D. ADDRESS 2352 Gwynn St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11040

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11040

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN ALLEN		2. DATE AND HOUR OF DEATH 10-29-68 10¹⁵ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
				C. CITY OR TOWN Baltimore Md. 9-5 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1907 Oakhill Ave.	
5. SEX M.	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1900 68	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?			11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.		
13. FATHER'S NAME David Allen			14. MOTHER'S MAIDEN NAME Julia Devise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219 01 7400		17. INFORMANT Hospital Records
18. 482.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction 3 days (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Infarction 3 days (B) DUE TO, OR AS A CONSEQUENCE OF: Staphylococcal Pneumonia 7± days (C) 491X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3/0-24-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-21 1968 to 10-29 1968 , that (I) (we) lost saw the deceased alive on 10-29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Werner Beck M.D. DEGREE				23B. DATE SIGNED 10-31-68	
23C. PHYSICIAN'S NAME (Type) Werner Beck M.D. DEGREE				23D. ADDRESS Mercy Hospital, Baltor	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 2, 68		24C. NAME of CEMETERY or CREMATORY Prospect Hill	
24D. LOCATION (City, town, or county) (State) Towson, Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204			



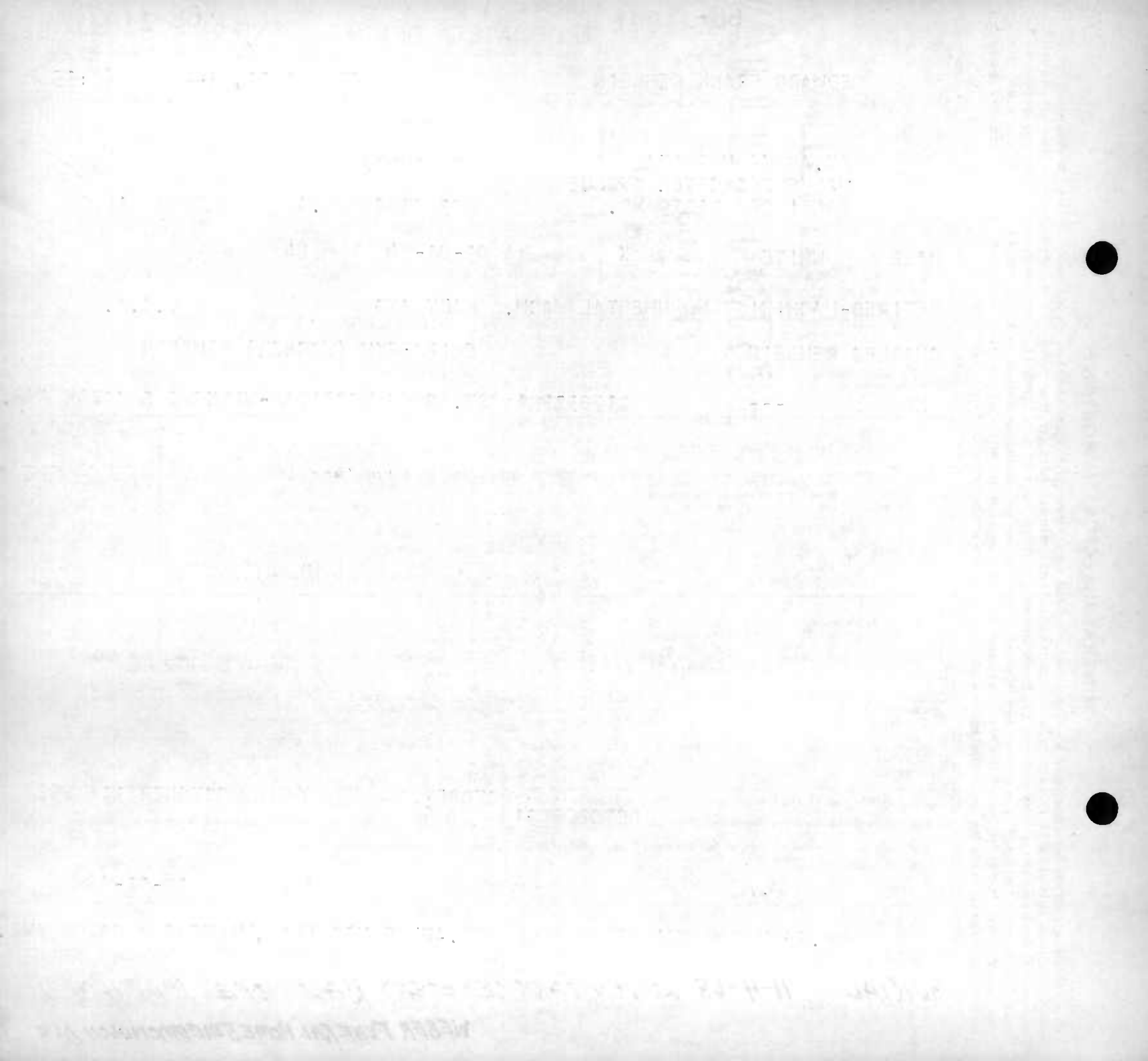
.B , 53-53 , 111 - 112 113 114 , 115 .

116 . 117 , 118 , 119 , 120 - 121 .

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG NO. 68-11041
68-11041				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD FRANK REHBEIN		
2. DATE AND HOUR OF DEATH OCTOBER 31, 1968 (9:35 P.M.)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229 MD.		
6. STREET AND NUMBER 603 CROSBY ROAD		7. ZONE 21207		
8. SEX MALE	9. RACE WHITE	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 03-01-84	12. AGE (In years last birthday) 84
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-MACHINIST		14. KIND OF BUSINESS OR INDUSTRY MONUMENTAL MACH.		15. BIRTHPLACE (State or foreign country) MARYLAND
16. CITIZEN OF WHAT COUNTRY? U.S.A.		17. FATHER'S NAME CHARLES REHBEIN		
18. MOTHER'S MAIDEN NAME ELIZABETH (WAGNER) REHBEIN		19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO ---		
20. SOCIAL SECURITY NO. 217032291		21. INFORMANT ADDRESS ST. AGNES HOSPITAL-WILKENS & CATON AVE.		
22. CAUSE OF DEATH 5-6-9-9 I		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3-7-8-8 II		25. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema (B) Heart Failure (C) Upper Gastrointestinal Bleeding		
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) NO
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
33. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?
36. I certify that (I) (this hospital) attended the deceased from OCTOBER 29 1968 to OCTOBER 31 1968 , that (I) (we) last saw the deceased alive on OCTOBER 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
37. SIGNATURE 		38. DATE SIGNED 10-31-68		39. PHYSICIAN'S NAME (Type) DR. SALVADOR QUIROZ
40. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.				
41. BURIAL CREMATION, REMOVAL (Specify) BURIAL	42. DATE 11-4-68	43. NAME OF CEMETERY or CREMATORY LODGE PARK CEMETERY		44. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
45. DATE REC'D BY HEALTH DEPT. NOV 4 1968	46. NAME OF REGISTRAR Q. L. E. Taylor	47. FUNERAL DIRECTOR ADDRESS WEBER FUNERAL HOME 5311 EDMONDSON AVE		



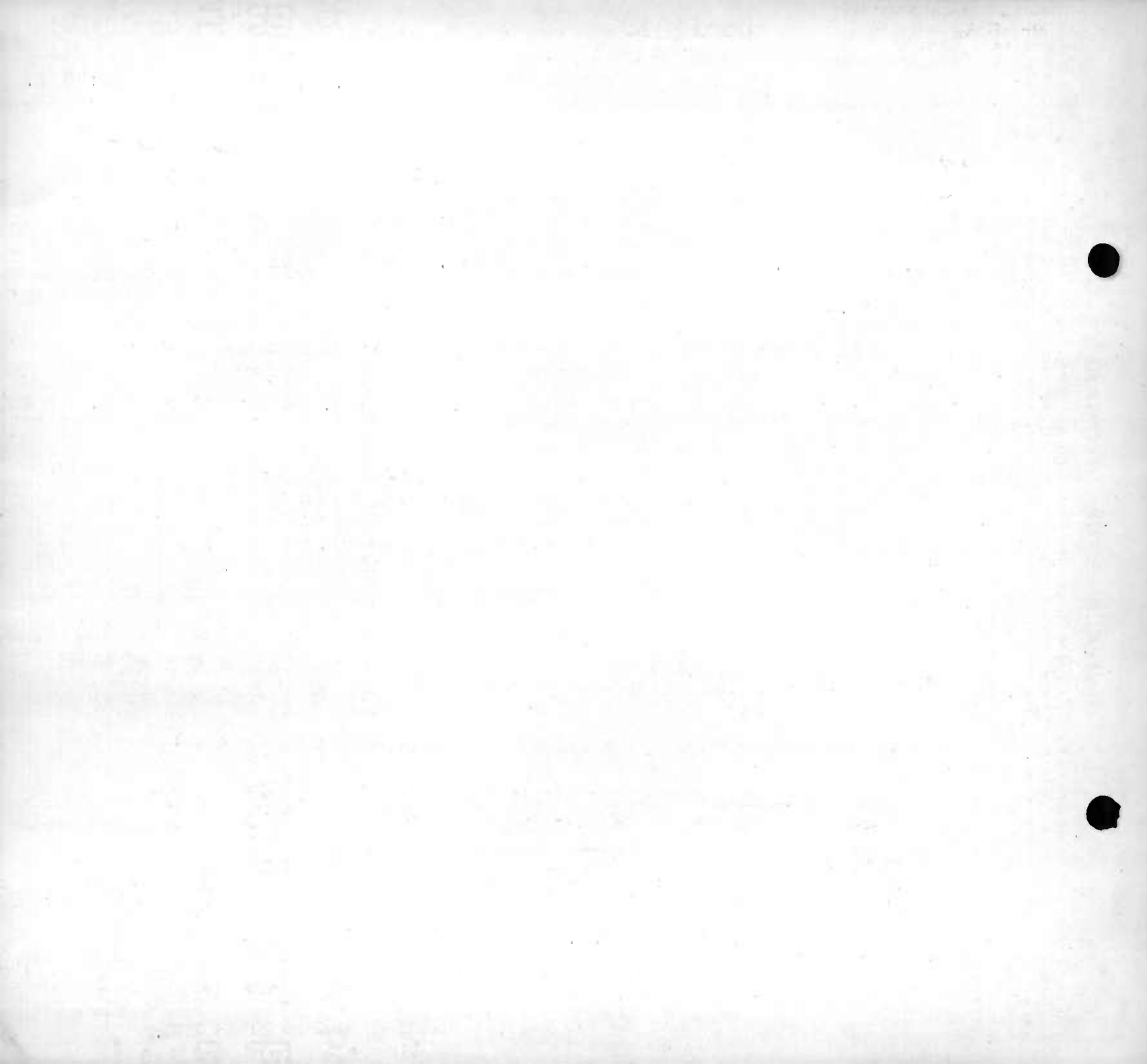
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11042

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MILDRED MARIE ROSEGRANT		NOV. 2, 1968 12:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 2218 East North Avenue				MARYLAND	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2218 East North Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
F.	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 9, 1907	61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Wilbur Brogunier				Elizabeth Owens	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213 28 6512		Mr. Joseph A. Rosegrant 2218 E. North	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(c) _____	
156.1 II				Arteriosclerotic C-V disease	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Sept. 19, 1968		Suspect of cause of death		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from June 1961 to Nov. 2, 1968, that (I) (we) lost saw the deceased alive on Sept. 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harold Harbold M.D.				Nov. 4, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Harold Harbold M.D.				4706 Harford Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/5/68		Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Maryland 21214	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 4 1968		J. G. 6 21 30		HENRY SANDER & SONS INC. Baltimore, Maryland 21218	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11043

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIOLA OVERTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year November 2, 1968		Hour 5:15 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 2, 1968		Hour 5:15 A.M.
6. SEX female		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. AGE (In years lost birthday) 3/24/54		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY?
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FEELER		14B. KIND OF BUSINESS OR INDUSTRY CANNING CO.		15. MOTHER'S MAIDEN NAME LULU JONES
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-07-3223		18. INFORMANT SAMUEL OVERTON JR.
19. 412.74-230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 11/7/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11/2/68				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/7/68		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY
24D. LOCATION (City, town, or county) (State) A. A. COUNTY. Md		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		
25B. NAME OF REGISTRAR Joseph J. Rock		25C. FUNERAL DIRECTOR 1304 N. Central Ave		

WALTER POLICE

Walter

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

68-11044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11044

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas B. Wilson</i>		2. DATE AND HOUR OF DEATH <i>11-1-68</i> <i>7:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> 8. COUNTY <i>BALTO</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIVERSITY OF MARYLAND HOSP.</i>			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>1823 N. VINE ST.</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <i>SP</i> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-27-26</i>		9. AGE (In years last birthday) <i>42</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>	
13. FATHER'S NAME <i>John E. Boozar</i>			14. MOTHER'S MAIDEN NAME <i>Ellie Davis</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John E. Boozar</i> ADDRESS <i>109 Edgewood St.</i>	
18. <i>291.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Delirium tremens</i> (B) <i>chronic alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Chronic pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12-18 hrs.</i> <i>Unknown</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>307X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>10-31</i> <i>19 68</i> to <i>11-1</i> <i>19 68</i> , that (1) (we) last saw the deceased alive on <i>11-1</i> <i>19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael G. Hayes, M.D.</i>			23B. DATE SIGNED <i>11-1-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Michael G. Hayes, M.D.</i>
23D. ADDRESS <i>Univ. of Md. Hospital</i>			24A. BURIAL CREMATION, REMOVAL <i>Burial</i>		
24B. DATE <i>11/4/68</i>			24C. NAME OF CEMETERY OR CREMATORY <i>St. Agnes Cem. Balto. Md.</i>		
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>			25A. DATE RECD. BY HEALTH DEPT.		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i> ADDRESS <i>319 N. Howard St.</i>		

James E. Brown
No.

12-27-25

Geo. H. M.
E. J. Davis

for the year 1925

Received of the Treasurer of the County of ...
the sum of ...

R-000

68-11045 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11045

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA RAY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

October 30, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

1108 N. Parrish Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

October 30, 1968

7:15 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Dec. 25, 1914

10. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1108 N. Parrish Street

11. BIRTHPLACE (State or foreign country)

Howard Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Dorsey

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

James Ray 1108 Parrish St.

19. 412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 31, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/5/1968

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 4 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Williams Funeral Home 314 N. Schrock St.

ADDRESS

Dec. 2nd 1894
Hoyt & Co. 115
Convent St
No

John Dorsey
Harry J
James 115 Convent St

Chas. T. Light

James W. McMillan Co. 115 Convent St
115 Convent St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
68-11046					CERTIFICATE OF DEATH					REG. NO. 68-11046									
BIRTH NO.										1. NAME OF DECEASED (Type or Print) <u>Abraham Steinhart</u>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD										2. DATE AND HOUR OF DEATH <u>11-3-68</u> <u>12</u> <u>12:55</u> <u>A.</u> M.									
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>1 Md.</u> B. COUNTY <u>27-44</u>									
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)										C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										E. STREET AND NUMBER <u>3002 Wisteria Ave.</u>									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>										8. DATE OF BIRTH <u>05-22-89</u> 9. AGE (In years last birthday) <u>79</u>									
10B. KIND OF BUSINESS OR INDUSTRY <u>Pharmacist</u>										11. BIRTHPLACE (State or foreign country) <u>Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>										13. FATHER'S NAME <u>Leopold Steinhart</u>									
14. MOTHER'S MAIDEN NAME <u>Frances</u>										15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>									
16. SOCIAL SECURITY NO. <u>214-03-7301</u>										17. INFORMANT <u>Milton Steinhart</u> ADDRESS <u>Same</u>									
18. CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cor Pulmonale</u>									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(B) Restrictive Lung Disease									
ANTECEDENT CAUSES										(C) Kyphoscoliosis									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																			
19A. DATE OF OPERATION <u>745X II</u>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No) <u>0</u>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (APPROX.)									
21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?									
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																			
22. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> <u>1968</u> to <u>11-3</u> <u>1968</u> .										that (I) (we) last saw the deceased alive on <u>11-3</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Delta C. Gandy, M.D.</u>										23B. DATE SIGNED									
23C. PHYSICIAN'S NAME (Type) <u>Delta C. Gandy, M.D.</u>										23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>										24B. DATE <u>11/5/68</u>									
24C. NAME OF CEMETERY or CREMATORY <u>Loudon PK.</u>										24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1968</u>										25B. NAME OF REGISTRAR <u>Robert E. Gandy</u>									
25C. FUNERAL DIRECTOR <u>Wm. J. Tucker & Sons</u>										ADDRESS <u>Baltimore, Md.</u>									

1/10/1918

Friday

1/10/1918

1/10/1918

1/10/1918

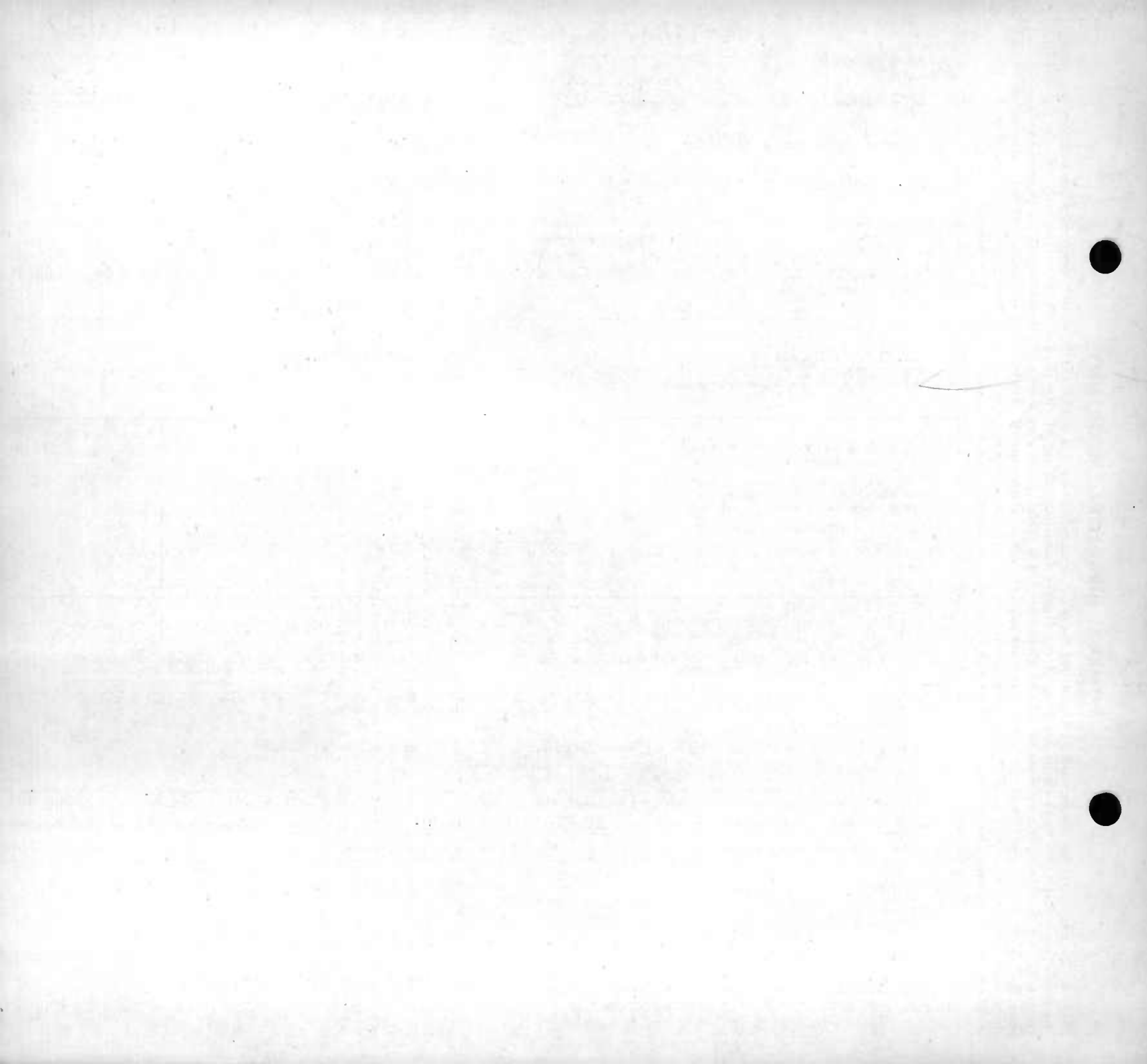
1/10/1918

1/10/1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11047
BIRTH NO. 68-22596 1. NAME OF DECEASED (Type or Print)		68-11047 CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		2. DATE AND HOUR OF DEATH 10/30/68 7:27 a.m. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2120 E. Hoffman St.			
5. SEX Male	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/68	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Lloyd Arrington			14. MOTHER'S MAIDEN NAME Brenda Hanks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from 10/30 19 68 to 10/30 19 68, that (I) (we) last saw the deceased alive on 10/30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry S. Verkauf, M.D.				23B. DATE SIGNED 10/30/68	
23C. PHYSICIAN'S NAME (Type) Barry S. Verkauf, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10/31/68		24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-11048</u>	
BIRTH NO. <u>68-21038</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>68-21038</u>		1. NAME OF DECEASED (Type or Print) BABY GIRL RACHELSKY		2. DATE AND HOUR OF DEATH <u>10-31-68</u> <u>2:15</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 Johns Hopkins Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>550 NORTH BROADWAY</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>10-31-68</u>	9. AGE (In years, lost birthday) <u>N.B.</u>	10. Under 1 Yr. Months: Days: Hours: Min. <u>— — — 30</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>GARY S. RACHELEFSKY</u>		14. MOTHER'S MAIDEN NAME <u>GAIL HASS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>776.21</u> <u>anoxia</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>(monitored)</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>773.0 II</u> <u>await autopsy</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> <u>1968</u> to <u>10/31</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>10/31/68</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.L. Carey</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>10-31-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.L. CAREY</u>		23D. ADDRESS <u>100 W. COLD SPRING LA 21210</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>XXXXX</u>		24B. DATE <u>10/31/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Johns Hopkins Hospital Balto., Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Sabin</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	
				ADDRESS	

John Hopkins Hospital
June 1885

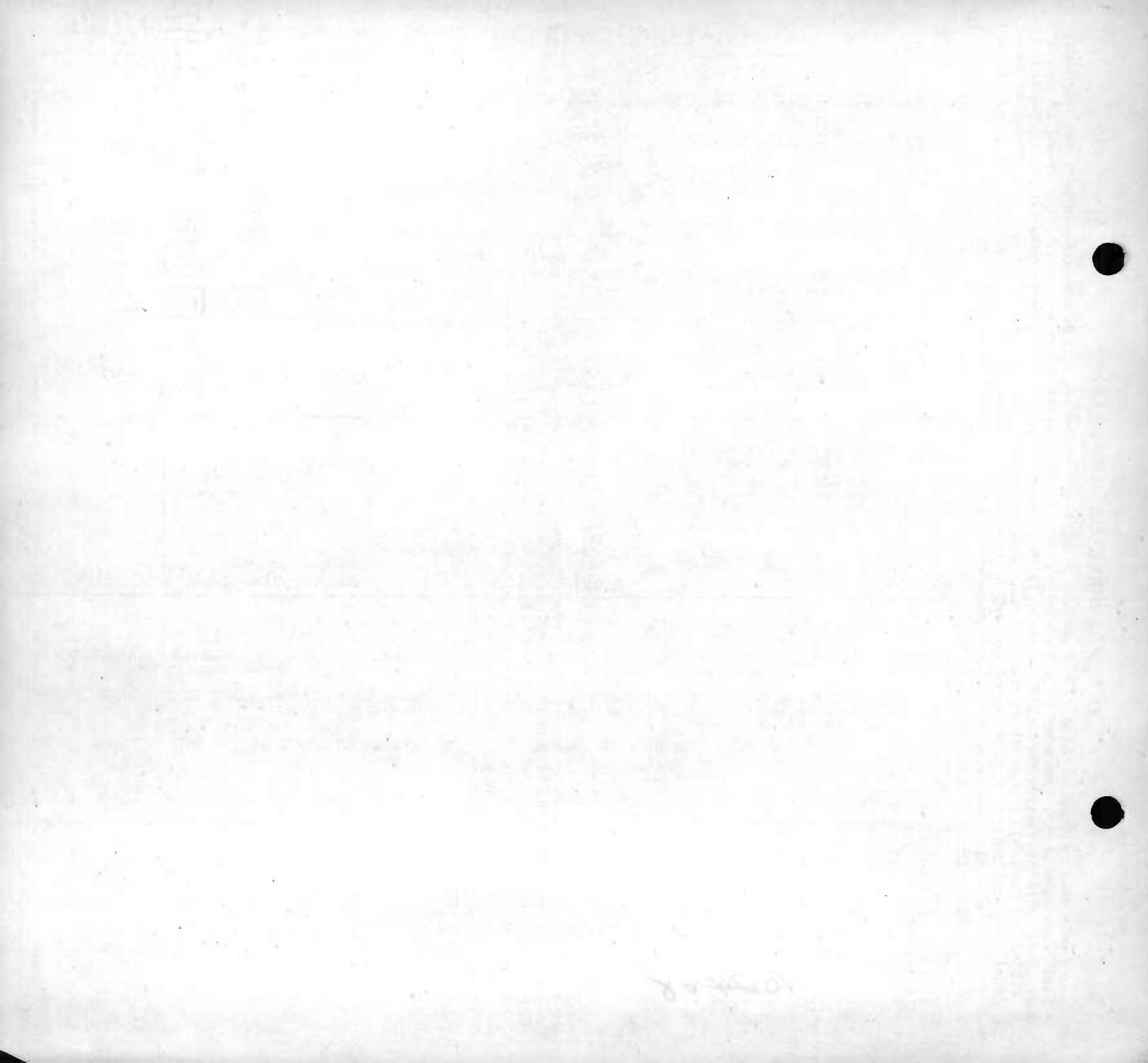
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11049 CERTIFICATE OF DEATH

REG. NO. 68-11049

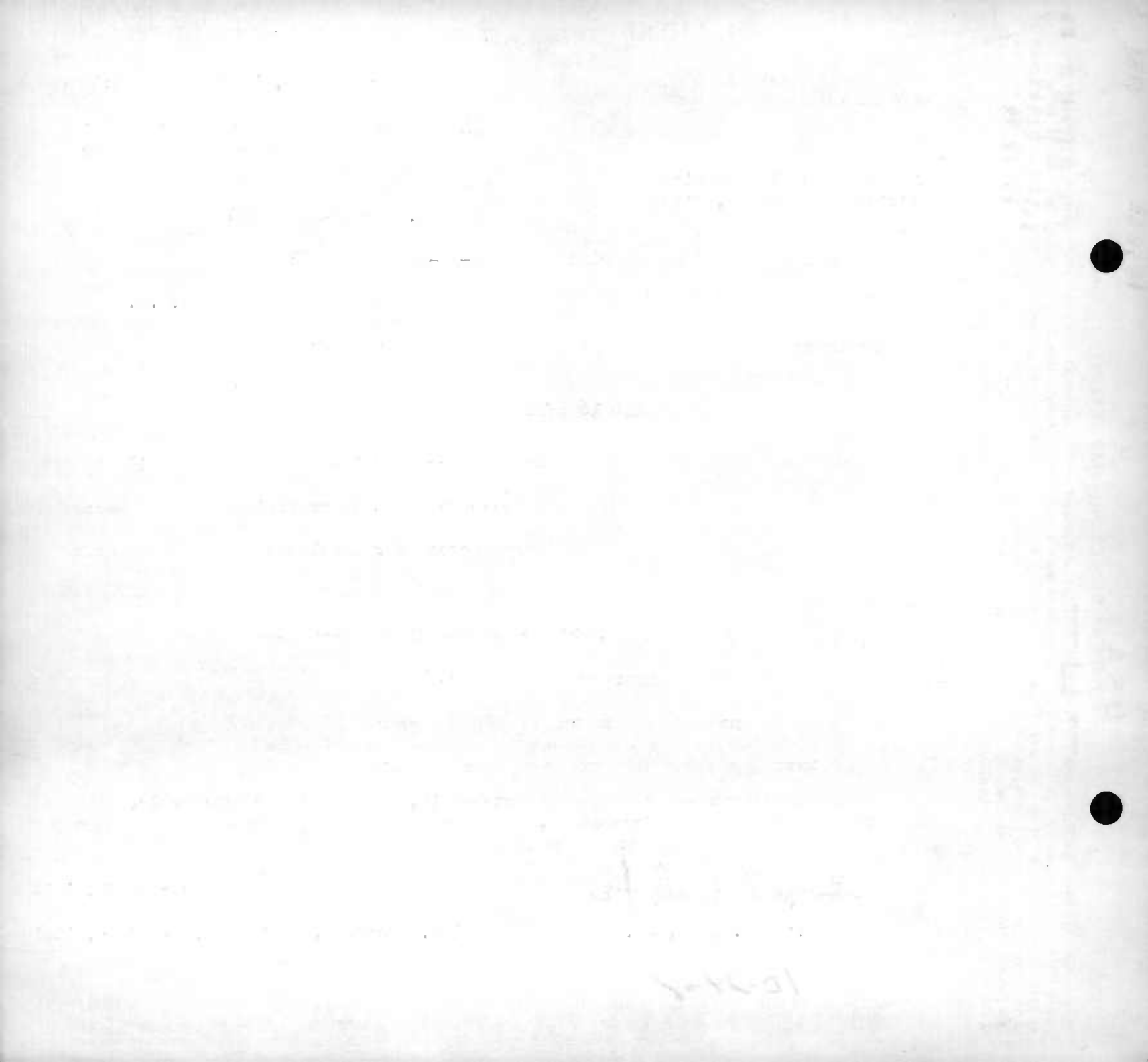
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mr. Homer Foote		2. DATE AND HOUR OF DEATH 10-16-68 8-45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 6-05		
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp. 35 Baltimore Md.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-25-90		9. AGE (In years lost birthday) 78		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME David H. Foote		14. MOTHER'S MAIDEN NAME Florence Pound	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.0 II ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia? Arterio Sclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Gross malnutrition, Pulmonary Tuberculosis? (C) Dehydration, Acute Gastroenteritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-7 1968 to 10-16 1968, and that (I) (we) lost saw the deceased alive on 10-16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 10-18-68	
23C. PHYSICIAN'S NAME (Type) J. P. A. E. SUBERS JR.				23D. ADDRESS Church Home & Hosp.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 10-24-68		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR		25D. MORTUARY SERVICE - BCHO			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11050	
BIRTH NO. 215		68-11050 CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH October 20, 1968 2:40 PM M.	
1. NAME OF DECEASED (Type or Print) Einar Aspen		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Maryland	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ths Johns Hopkins Hospital Baltimore, Maryland, 21205		C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore City	
5. SEX Male		D. STREET ADDRESS (If rural, give location) 241 S. Broadway 21231	
6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 05-17-96	9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anton Aspen		14. MOTHER'S MAIDEN NAME Estrie Yautson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216 16 572	17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Tracheal obstruction and apnea DUE TO Tracheostomy and Heart Failure (B) Laryngectomy for Carcinoma DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 15-0X II Carcinoma of the distal esophagus			
19A. DATE OF OPERATION none	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED xxxxxxx	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) xxxxx	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) xxxx	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) xxxx	21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? xxxxxx	
22. I certify that (I) George H. Sack, Jr. attended the deceased from October 19, 1968 to October 20, 1968 , that (I) we last saw the deceased alive on October 20, 1968 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.			
23A. SIGNATURE George H. Sack, Jr.			23B. DATE SIGNED October 20, 1968
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr.		23D. ADDRESS 601 N. Broadway, Baltimore, Maryland, 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) 10-24-68	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968	25B. NAME OF REGISTRAR 12-25-8, J. J. J.	25C. FUNERAL DIRECTOR MORTUARY SERVICE	ADDRESS BCHD



FUNERAL DIRECTOR: IMPORTANT

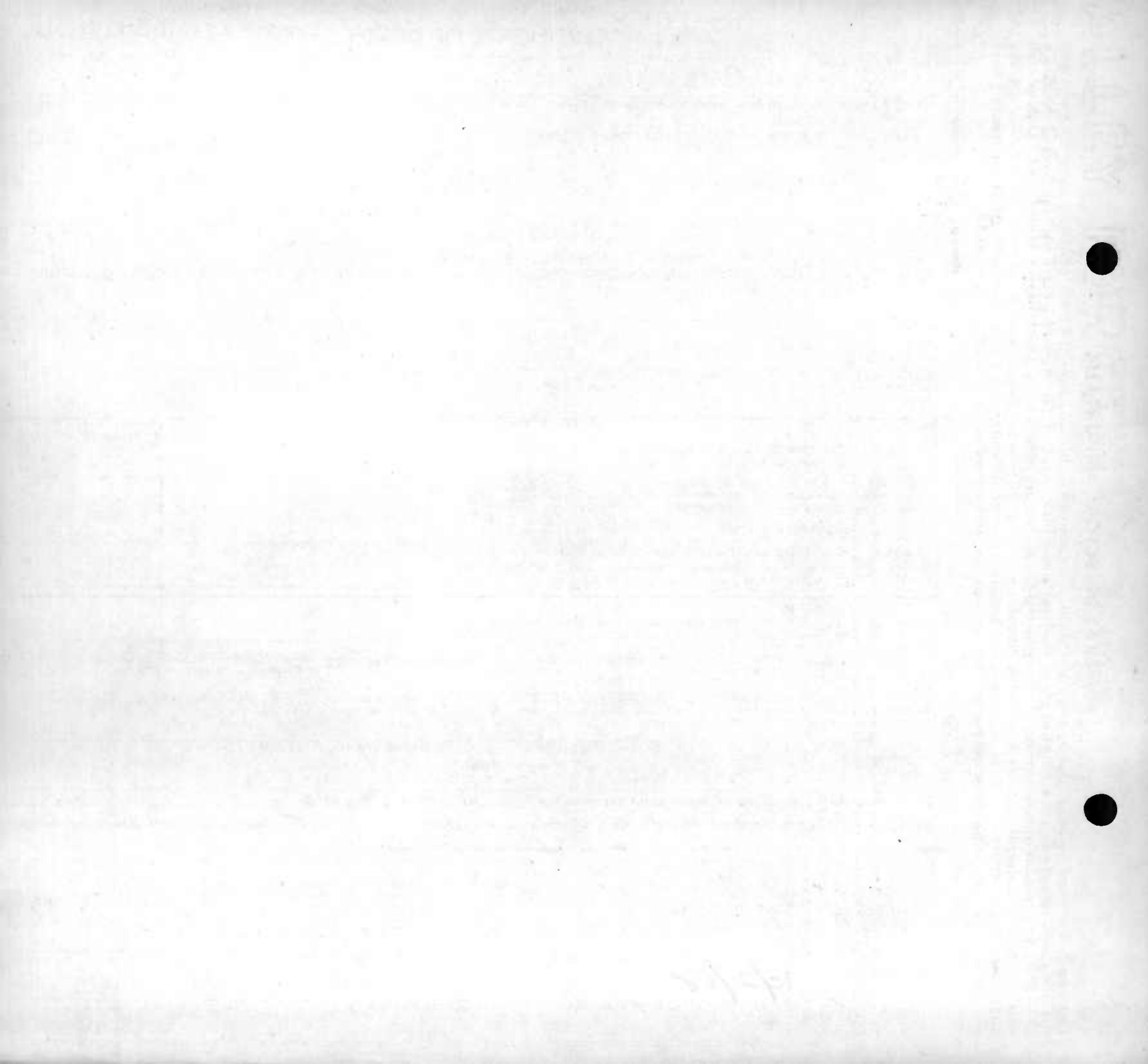
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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11051	4
BIRTH NO. 68-19626		68-11051		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Boy Fetterman			2. DATE AND HOUR OF DEATH 10/16/68 12:18 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital			C. CITY OR TOWN Baltimore Md		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 39 Beach Drive					
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/66	9. AGE (In years last birthday) 1 day	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
13. FATHER'S NAME Robert Fetterman			14. MOTHER'S MAIDEN NAME Carol		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: respiratory acidosis (B) diaphragmatic hernia DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION 10/15/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED diaphragmatic hernia		
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/15/68 19 68 to 10/16 19 68, that (I) (we) last saw the deceased alive on 10/16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence D. Robinson Jr MD			23B. DATE SIGNED 10/16/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/21/68		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. NOV 4 1968		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. MORTUARY SERVICE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11052
BIRTH NO. <u>68-08912</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BROWN, BABY GIRL "B"</u>		2. DATE AND HOUR OF DEATH <u>5/9/68</u>		9:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Balto.</u>		A. STATE <u>MD.</u>		B. COUNTY <u>Balto.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4014 Spruce Drive</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/68</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Anfield</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>769.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>6:40 a.m. 5/9 1968</u> to <u>9:25 p.m. 5/9 1968</u> , that (1) (we) last saw the deceased alive on <u>9:25 p.m. 5/9 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph H. Richman, MD</u>				23B. DATE SIGNED <u>5/9/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph H. Richman, MD</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10/21/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

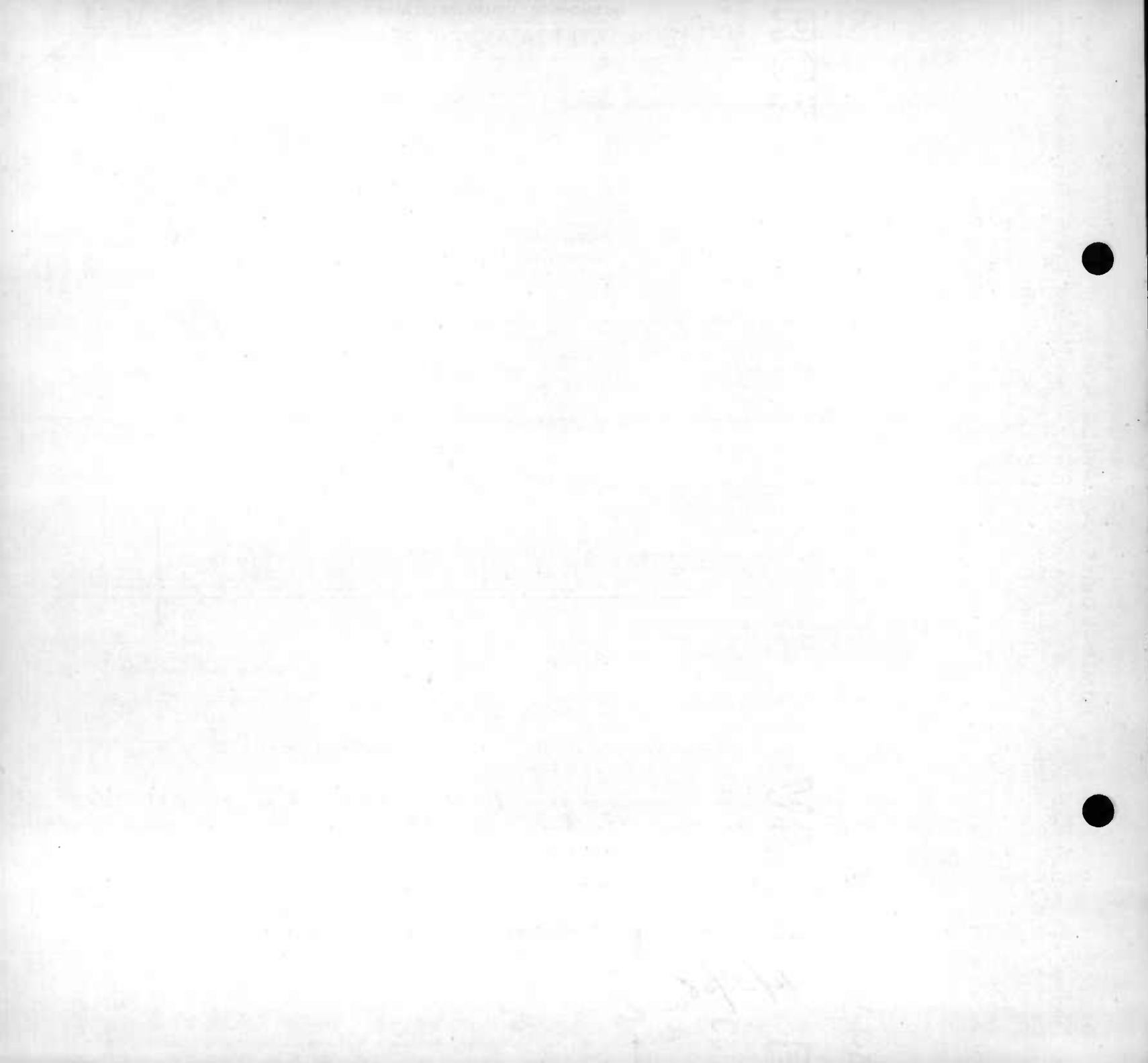
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11053
BIRTH NO. 68-19546		68-11053 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) CUNNINGHAM BABY BOY		2. DATE AND HOUR OF DEATH 10/14/68 10:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE and. B. COUNTY Balto.		
5. SEX M		6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/68
9. AGE (In years lost birthday) newborn		10. CITIZEN OF WHAT COUNTRY? USA		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME CUNNINGHAM 628 E 35 ST.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY (B) HYALINE MEMBRANE DYS. (C) _____		
19. 773.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION R	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from Oct. 12 19 68 to Oct 14 19 68, that (1) last saw the deceased alive on Oct. 14, 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (No) (Yes) view the body after death.				
23A. SIGNATURE Todd M. Gladstone, M.D.		23B. DATE SIGNED Oct		23C. PHYSICIAN'S NAME (Type) Todd M. Gladstone, M.D.
23D. ADDRESS Sinai Hospital of Baltimore		23E. FUNERAL DIRECTOR ADDRESS MORGUARY SERVICE - BCHD		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 10/21/68	24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1968		25B. NAME OF REGISTRAR MORGUARY SERVICE - BCHD		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11054	X
BIRTH NO. 68-18965 68-11054		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy		2. DATE AND HOUR OF DEATH Balis 10-4-68 7:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md B. COUNTY 13-01 C. CITY OR TOWN 21217 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 830 Channcey St			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-68 3:15 PM	9. AGE (In years lost birthday) 3 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Edwin Roland Balis		14. MOTHER'S MAIDEN NAME Viola Y. Dix			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity 520gms. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-4 3:15 PM 1968 to 10-4-68 7:00 PM that (I) (we) lost saw the deceased alive on 10-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mariquita R. Cansino DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-4-68	
23C. PHYSICIAN'S NAME (Type) MARIQUITA R. CANSINO DEGREE		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) 10/21/68		24B. DATE		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS MORTUARY - BCHD			
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR R. J. E. Hallway		25C. FUNERAL DIRECTOR 2	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-11055

BIRTH NO. 68-20293

1. NAME OF DECEASED
(Type or Print)

Baba Bay Cheeseboro

2. DATE AND HOUR OF DEATH

10-26-68

7 00

A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland.

21230

C. CITY OR TOWN

INSIDE CITY LIMITS?

Baltimore

YES ☒

NO ☐

E. STREET AND NUMBER

702 Carroll St.

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10-26-68

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

4

0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Pegg Jenkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 776X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Prematurity - gestation of 24 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

776X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-26-68 3pm 19 68 to 10-26 7pm 19 68, that (I) (we) last saw the deceased alive on 10-26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley R. Weiner, M.D. DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

10-26-68

23C. PHYSICIAN'S NAME (Type)

Stanley R. Weiner M.D. DEGREE

23D. ADDRESS

South Baltimore General Hospital, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

10-30-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

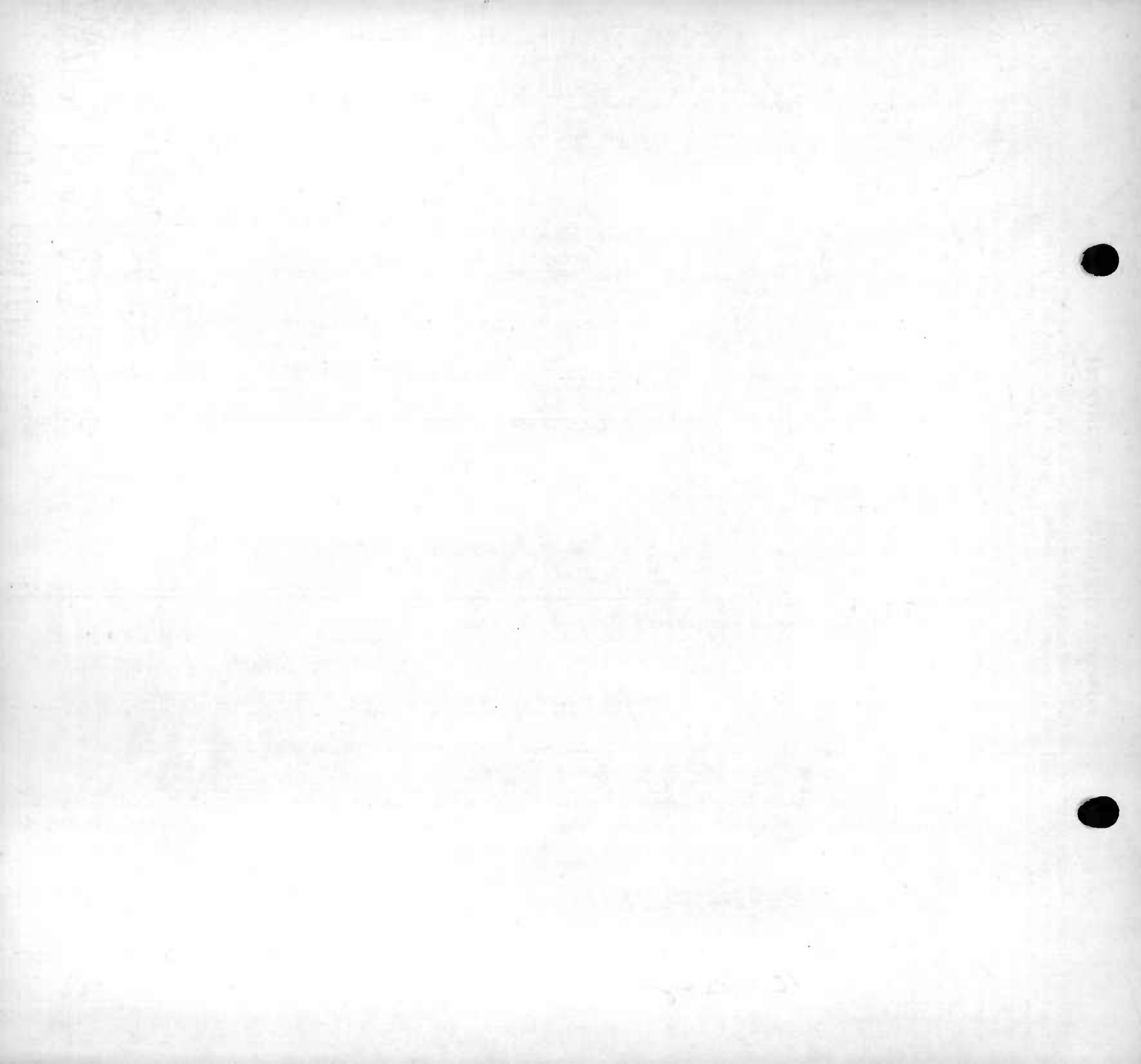
ADDRESS

NOV 4 1968

Dr. E. S. S. S.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11056 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11056

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MATTHEW EMERSON		2. DATE AND HOUR OF DEATH 10/27/68 3: A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1124 N. Fulton Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 23, 1889	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME John Crispden		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-4126		17. INFORMANT From chart	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C. V. A. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
18. 331 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/25/68 19 68 to 10/27 19 68 , that (I) (we) last saw the deceased alive on 10/27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. S. Ming				23B. DATE SIGNED 10/27/68	
23C. PHYSICIAN'S NAME (Type) CHEE SHWE MING		23D. ADDRESS Lutheran Hospital of Maryland.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-31-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Deane E. Johnson		25C. FUNERAL DIRECTOR Joseph W. Spinn		25D. ADDRESS 2222 W. North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11057 CERTIFICATE OF DEATH

REG. NO. 68-11057

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alfreda R. Bagley		10-26-68 2:28 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland			
39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2601 Woodview Rd.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro		12-7-96	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed		Housewife		Virginia (Blackstone)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S. A.		Douglass Clark		Lelia A. Reece	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-18-0152		William D. Campbell 5526 Rosworth Ave	
18. 427.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure			
		(B) Atrial Fibrillation DUE TO, OR AS A CONSEQUENCE OF:			
		(C).....			
433.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1-68 19 to 10-26-68 19 that (I) (we) last saw the deceased alive on 10-26-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Gregorio S. Tengco, MD		10/26/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Gregorio S. Tengco, MD		1514 Division St. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-30-68		Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Baltimore Md.		NOV 4 1968		J. Joseph	
		25C. FUNERAL DIRECTOR		25D. ADDRESS	
		J. Joseph		2222 NORTH AVE.	

FUNERAL DIRECTOR: IMPORTANT

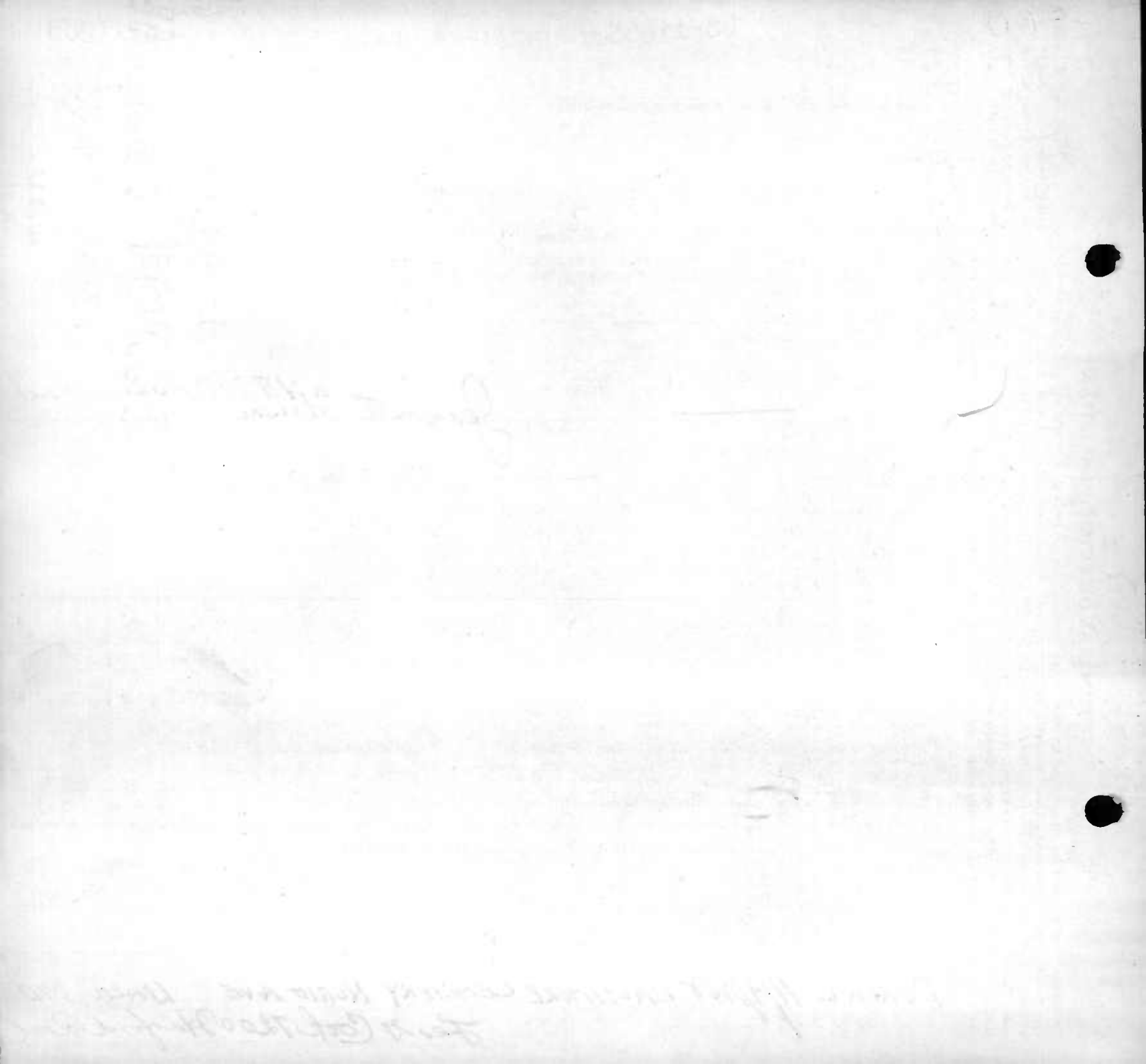
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11058 CERTIFICATE OF DEATH

REG. NO. X

68-11058

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MINNIE MABLE GUY		2. DATE AND HOUR OF DEATH 10/31/68 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEM. HOSP.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO.	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/17/93		9. AGE (In years last birthday) 75		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Jeanette Wilson	
18. ADDRESS 1733 Amuska Road		CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular Fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 433.1 II		(B) Atherosclerotic Cardiovascular Disease		10 yrs	
(C) Uremic Renal Failure				10 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 68 to 10/31 19 68 , that (I) (we) lost saw the deceased alive on 10/31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN D. JENSEN MD				23B. DATE SIGNED 10/31/68	
23C. PHYSICIAN'S NAME (Type) ALLAN D. JENSEN, MD				23D. ADDRESS UNION MEM. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/4/68		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE RECD BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Robert G. Seligman		25C. FUNERAL DIRECTOR Leah Cook 7200 Harford Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11059

BIRTH NO.		1. NAME OF DECEASED (Type or Print) David Finkelstein		2. DATE AND HOUR OF DEATH November 3, 1968 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
3510 Ellerslie Ave				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3510 Ellerslie Ave			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1906	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Morris Finkelstein		14. MOTHER'S MAIDEN NAME Bessie Koenigberg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-6012		17. INFORMANT Mrs Margaret Finkelstein	
				ADDRESS Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intensified cardiac condition		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28 19 68 to 11/3 19 68 , that (I) (we) last saw the deceased alive on 10/16 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham Genecin M.D. OEGREE				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) Abraham Genecin M.D.		23D. ADDRESS 611 Park Ave Baltimore, Md. OEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland	
				ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11060 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11060

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HEILMAN, LEWIS TOMER		2. DATE AND HOUR OF DEATH Nov. 2nd 1968 11.15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 7233 HARFORD ROAD		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-16-02	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? AMERICAN			13. FATHER'S NAME Howard U. Heilman		
14. MOTHER'S MAIDEN NAME Luc retia Smith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-07-8794			17. INFORMANT Mrs. LAVERNA HEILMAN		
18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Ruptured Abdominal Aneurysm			(B) Arteriosclerosis C.V.D.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 451X II					
19A. DATE OF OPERATION 10/29/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal Aortic aneurysm		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 29 19 68 to Nov. 2nd 19 68 , that (I) (we) last saw the deceased alive on Oct Nov. 2nd 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Russ Y Cho				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Russ Y Cho				23D. ADDRESS Dorsey, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-68		24C. NAME OF CEMETERY or CREMATORY Meadowridge	
24D. LOCATION (City, town, or county) (State) Dorsey, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS 5805 Harford Rd.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11061

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) DAISY T. BOWEN				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year November 1, 1968		Hour 11:55 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968		Hour 11:55 P.	
6. SEX female		7. RACE white		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-8-80		10. AGE (In years last birthday) 88		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Fannie Horisburg	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 217-36-3070		18. INFORMANT Daniel W. Tilman, 7903 Springway Rd.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E 880 X				CAUSE OF DEATH Cranio-cerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 900.0 II							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4001 Ridgcroft Road (cellar)				22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10/29/68 7:45 P. - 8:00 P. m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subj. fell down cellar stairs			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 11/2/68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-68		24C. NAME OF CEMETERY or CREMATORY Loudon Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS	

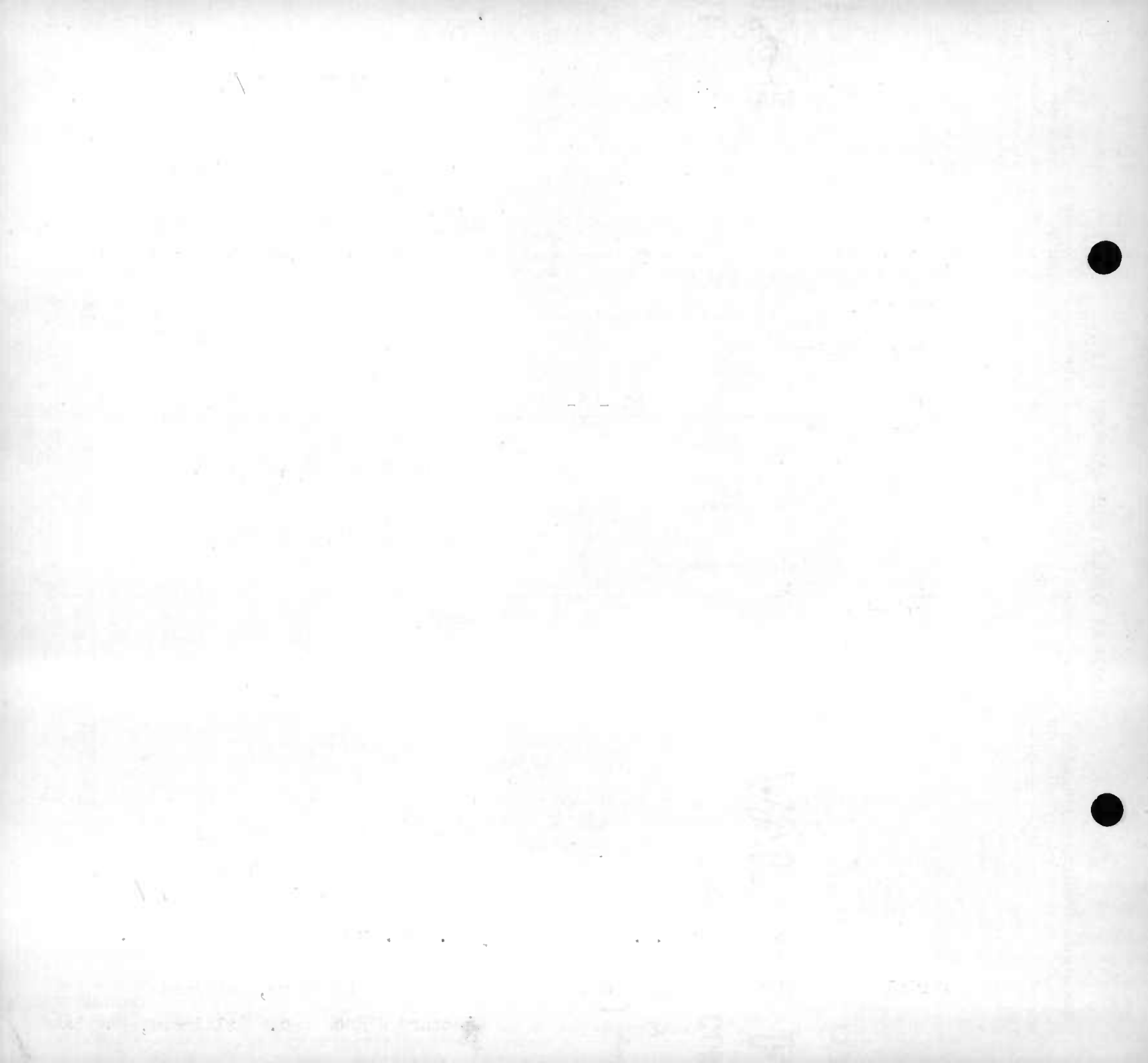
WALL 11/11/11

James J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Katherine P Eigner		2. DATE AND HOUR OF DEATH 11/2/68 11/2/68 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3521 Ail sa Ave.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-05-83	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George Kilian			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-5920		17. INFORMANT Ruth Eubank ADDRESS 7001 E. Durham Way 21222	
18. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio Vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Digitalis Intoxication (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-1 1968 to 11-3 1968 , that (I) (we) last saw the deceased alive on 11-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Delfa C. Gomez, M.D.				23B. DATE SIGNED 11/3/68	
23C. PHYSICIAN'S NAME (Type) Delfa C Gomez M.D.		23D. ADDRESS Md. Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/68		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 11 1968			
25B. NAME OF REGISTRAR Robert E. Salsbury		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland			



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5-300

68-11063

BALTIMORE CITY HEALTH DEPARTMENT

68-11063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Scott, Robinson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 11 , Day 3 , Year 1968 Estimated <input type="checkbox"/> Hour 1:55 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month 11 , Day 3 , Year 1968 Hour 1:55 AM	
6. SEX M		7. RACE C	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 21-01	
9. DATE OF BIRTH 1/24/21		10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME UNK.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Jeannett Winston		ADDRESS 820 Burgundy St.	
19. 4 12 41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/3/1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/7/68	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR Charles A. Rice	
25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11064

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11064

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Morris Smith		2. DATE AND HOUR OF DEATH 10-25, 1968 8:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		B. DATE OF BIRTH 6-1-97 9. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unk.	
14. MOTHER'S MAIDEN NAME Unk.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records		ADDRESS			
18. 162.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		10 days	
ANTECEDENT CAUSES		(B) Ca of Bronchus, Probable DUE TO, OR AS A CONSEQUENCE OF:		1 month?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Fistula Esophago-bronchial Possible Arteriosclerosis		week?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-15 1968 to 10-25 1968 , that (I) (we) last saw the deceased alive on 10-25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rifat Abouy MD				23B. DATE SIGNED 10/26	
23C. PHYSICIAN'S NAME (Type) Rifat Abouy MD				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-68		24C. NAME OF CEMETERY or CREMATORY mt auburn	
24D. LOCATION (City, town, or county) Baltimore md		24E. STATE (State) md		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A Rice		25D. ADDRESS 661 W. Bore St	

Mr. [illegible]
Baltimore
South Baltimore General Hospital 1417 Chesapeake Ave.
M C X 6-1-47
Ga

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10-12
10-10

68-11065

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11065

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) GEORGE BAKER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 1, 1968 Hour 4:55 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 1, 1968 4:55 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-23-40		10. AGE (In years lost birthday) 28 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Charlotte Co. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		14B. KIND OF BUSINESS OR INDUSTRY Steamship Trade	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 229-48-153	
15. MOTHER'S MAIDEN NAME Ruth Gertrude Dennis		18. INFORMANT Gertrude Baker	
13. FATHER'S NAME Warren R. Baker		E. STREET AND NUMBER 1204 W. Lexington Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9881X		CAUSE OF DEATH Fracture of Neck	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E904.9 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Old craniocerebral injury	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk/	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ?? ?? ??		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) UNK?		22F. HOW DID INJURY OCCUR? Unk?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 1, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 5 1968		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR MORTON & Dwyer		ADDRESS 1701 LAYRENS	

Exhibit 11-2-18 MT. Auburn, Baltimore
Horton & Dyer 1901

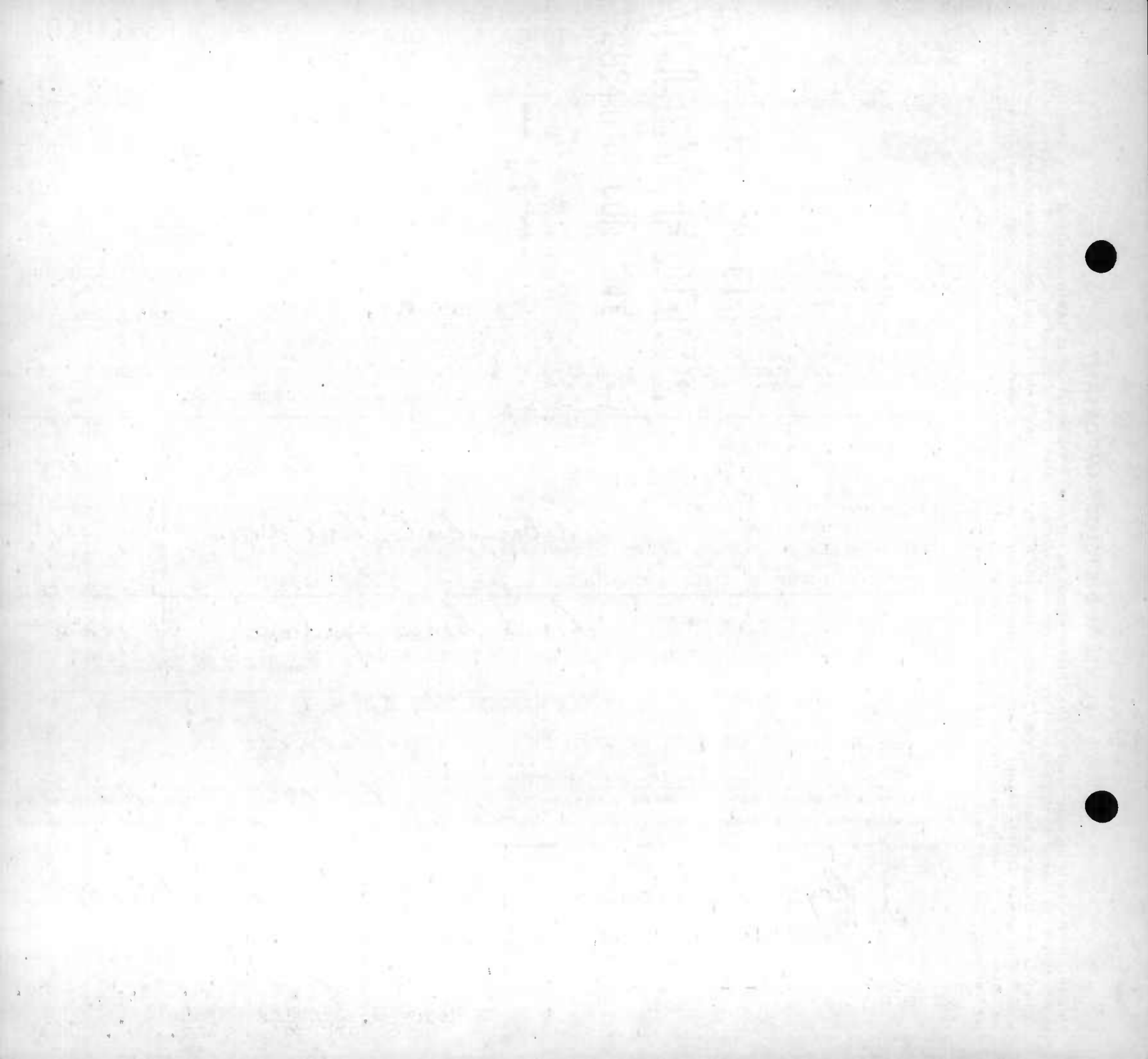
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11066 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11066

BIRTH NO.		1. NAME OF DECEASED (Type or Print) NELLIE B. DOUGHERTY		2. DATE AND HOUR OF DEATH 11/2/68 2:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Jenkins Memorial Hospital 1000 Caton Ave., Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 2803 North Howard Street	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1878	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Charleston, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Daniel McCarthy			
14. MOTHER'S MAIDEN NAME Mary Downey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-22-4228 A		17. INFORMANT ADDRESS Medical Records- Jenkins Mem'l			
18. 4-12-31 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF:		years	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II Above brain syndrome					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (4) (this hospital) attended the deceased from 10/7 19 08 to 11/2 1968 that (4) (we) last saw the deceased alive on 11/2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Raymond Gladue J. Raymond Gladue, M.D. DEGREE				23B. DATE SIGNED 11/2/68	
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				23D. ADDRESS 701 Brookwood Rd. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Woodlawn Balto., Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			



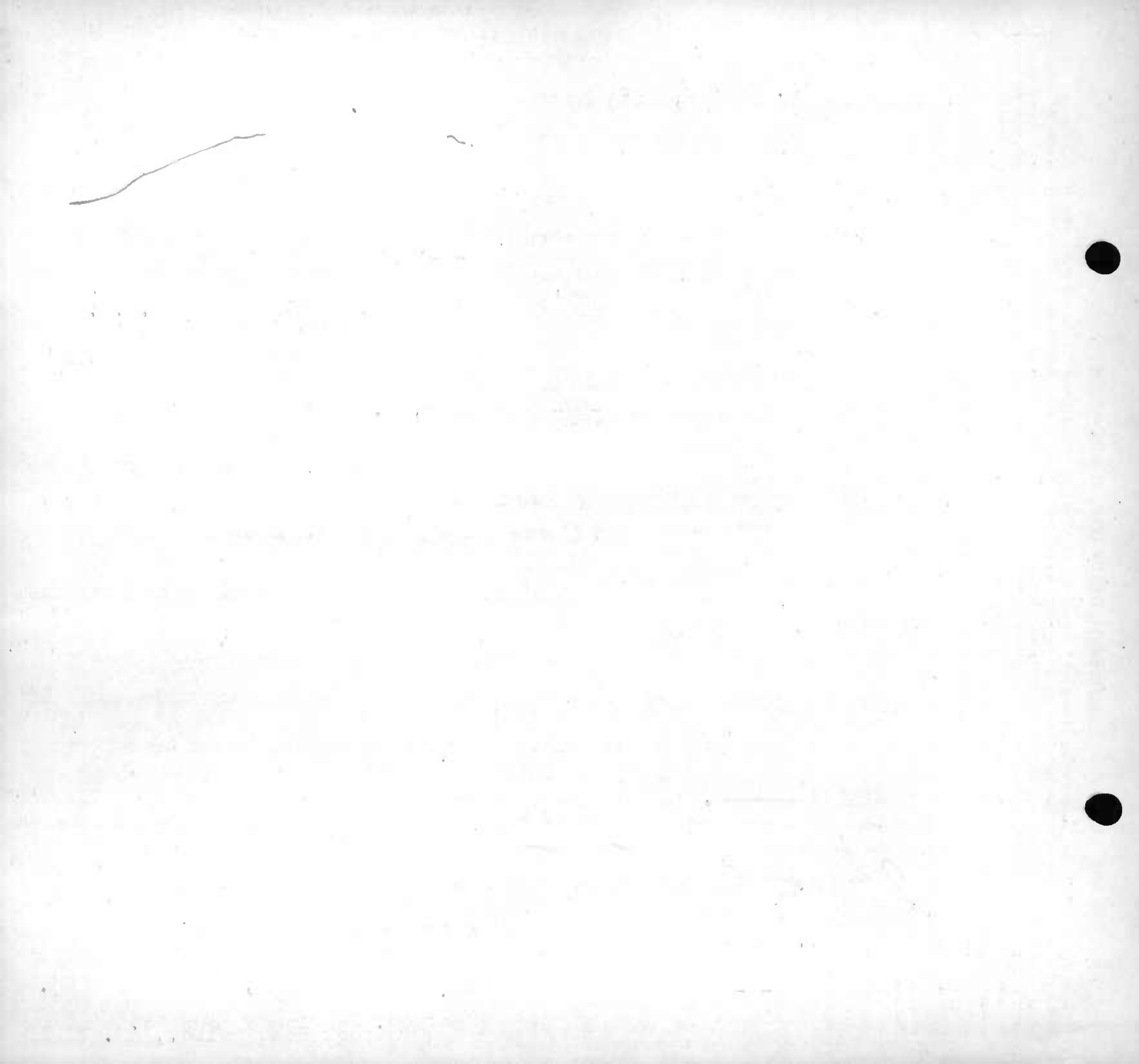
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11067 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11067

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		J. George Parr		Nov. 2, 1968 11 30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 1519 Pentridge Road Apt 229				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1519 Pentridge Road	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1891	9. AGE (in years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier			10B. KIND OF BUSINESS OR INDUSTRY Ret'd Horse Racing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Joseph Parr			14. MOTHER'S MAIDEN NAME Catherine Eberenz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 215-09-0557A		17. INFORMANT Mrs. J. George Parr
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 410.94-188X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCT 5 MIN B: ASCVD 10 YEARS C: CARCINOMA OF BLADDER 5-9 MONTHS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG 19 68 to NOV 2 19 68, that (I) (we) last saw the deceased alive on OCT 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Walter Smyth MD DEGREE				23B. DATE SIGNED Nov 2, 1968	
23C. PHYSICIAN'S NAME (Type) J. Walter Smyth MD DEGREE				23D. ADDRESS 550. N. Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME of CEMETERY or CREMATORY Gardens Dulaney Valley Mem.	
24D. LOCATION (City, town, or county) (State) Timonium, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968			
25B. NAME OF REGISTRAR Henry W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 4905 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11068

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Elsie Lilley Zimmerman		Oct. 30, 1968 4:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1 University Parkway East	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1880	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Ely Lilley		14. MOTHER'S MAIDEN NAME Eleanor Hinson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-1696		17. INFORMANT Charles R. Zimmerman 816 Beverly Ave	
				ADDRESS Bethlehem, Pa.	
18. 740.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: S. formiter 7/68 (B) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. 450.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1 to 10-30 1968, that (I) (we) last saw the deceased alive on 10-30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Abbott				23B. DATE SIGNED 11-1-68	
23C. PHYSICIAN'S NAME (Type) Dr. Thomas Abbott				23D. ADDRESS 4509 Liberty Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-68		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn Balto., Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1968		25B. NAME OF REGISTRAR C. J. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Balto., Md. 21212	

James M. Smith

1840-1841

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11069</u>
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Col. Roger Streett Whiteford</u>		2. DATE AND HOUR OF DEATH <u>November 2, 1968</u> <u>11:20</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Public Health Service Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Wyman Pk. Drive + 31st Street</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1904</u> 9. AGE (In years lost birthday) <u>64</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. (retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Roger S. Whiteford</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Kilgore</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates) <u>Yes</u> <u>USA 1941-45, Reserve</u>		16. SOCIAL SECURITY NO. <u>216-03-2881</u>		17. INFORMANT <u>Records - US PHS Hospital, Baltimore, Md.</u>
18. <u>379.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>327.21 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>August 27, 1968</u> 19 to <u>November 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>November 2, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>My Bantlos M.D.</u>		23B. DATE SIGNED <u>11-2-68</u>		23C. PHYSICIAN'S NAME (Type) <u>MIHALY BANTLOS, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arlington National</u>
24D. LOCATION <u>Arlington, Va.</u>		24E. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1968</u>		25B. NAME OF REGISTRAR <u>John E. Jenkins</u>		25C. ADDRESS <u>4905 York Road Balto., Md. 21212</u>

WYMOND PT. DISTRICT STATION
M. W. ✓
MAY 11 1904

Col. Jackson
KODON 2. W. H. T. P. C. A.
MAY 11 1904

YES NEW YORK, 11-12-04
KODON 2. W. H. T. P. C. A.
OCTOBER 11 1904

MIRALY BARTACK A. S.
KODON 2. W. H. T. P. C. A.
OCTOBER 11 1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11070

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charlotte Florence McVay		2. DATE AND HOUR OF DEATH Nov. 1, 1968 2 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel 52-00		
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) 71 yrs. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frank Andrews		
14. MOTHER'S MAIDEN NAME Anna Brown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-24-8533			17. INFORMANT Edgar McVay ADDRESS 716 South Camp Meade Rd. Linthicum Heights, Md.		
18. 445-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ARIDOSIS (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 43-0-1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC GANGRENE, RT FOOT (B) DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (C) 10 dys YRS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 64 to 10/31 19 68 , that (I) (we) last saw the deceased alive on 5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) view the body after death.					
23A. SIGNATURE F. J. Borges MD				23B. DATE SIGNED 11/1/68	
23C. PHYSICIAN'S NAME (Type) FRANCIS J. BORGES				23D. ADDRESS UNIV OF MD HPTL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 1968		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION Anne Arundel Co. Md.		24E. NAME OF REGISTRAR R. E. Taylor		24F. FUNERAL DIRECTOR H. J. Eckhardt	
24G. ADDRESS Owings Mills, Md.		24H. DATE REC'D BY HEALTH DEPT. NOV 6 1968		24I. NAME OF REGISTRAR R. E. Taylor	

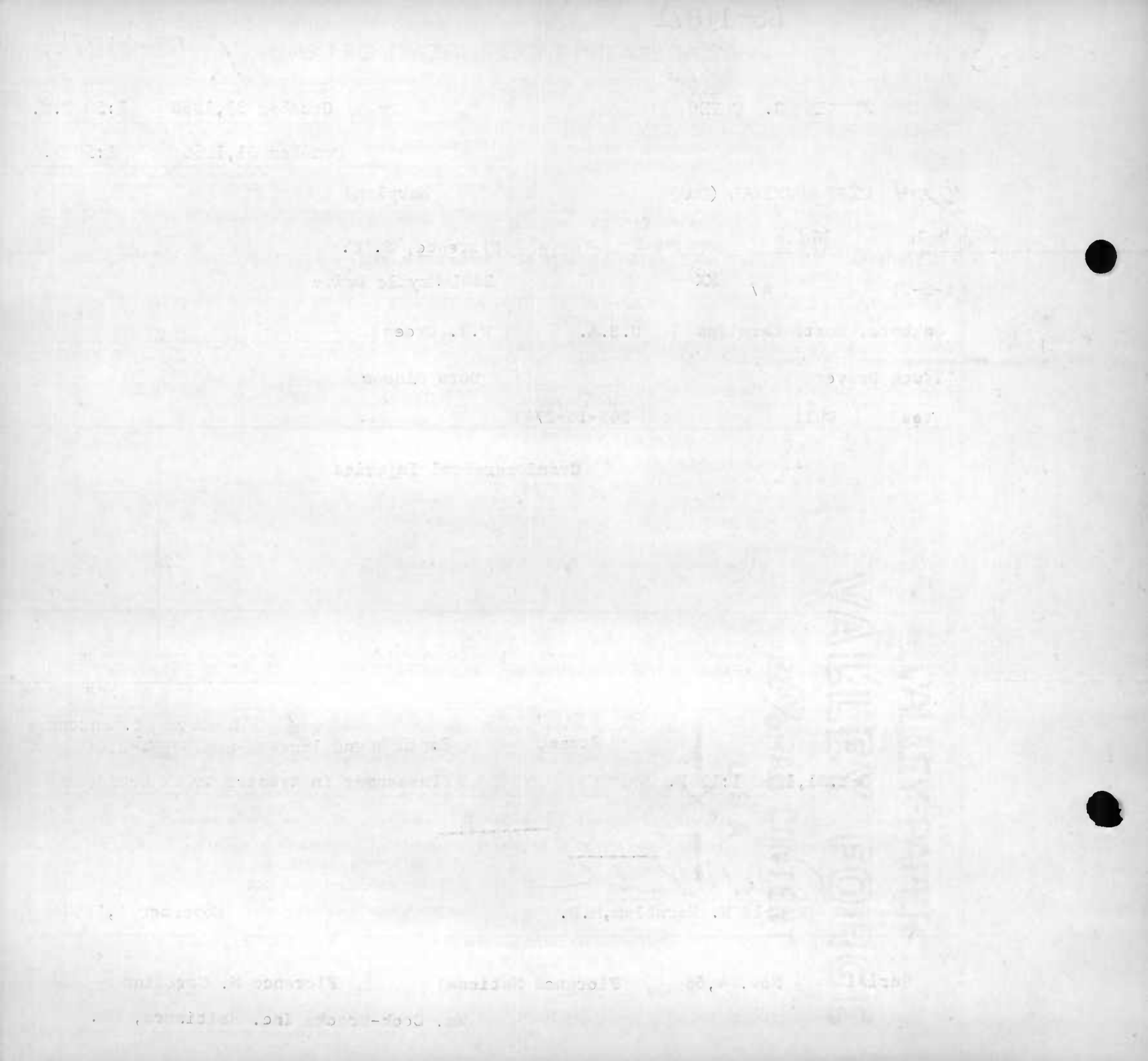
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11071

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JESSIE G. GREEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> October 31, 1968 Hour 1:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 13/99 CITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour October 31, 1968 1:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Florence, S. C.	
9. DATE OF BIRTH 1-2-21		10. AGE (In years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Oakboro, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW11		17. SOCIAL SECURITY NO. 245-16-2741	
15. MOTHER'S MAIDEN NAME Dora Hinson		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH E81211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cranio-cerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Lombard St. entrance South bound lane-Harbor tunnel		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Oct. 31, 1968 1:13 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in tractor truck accident	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 1, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 68	
24C. NAME OF CEMETERY or CREMATORY Florence National		24D. LOCATION (City, town, or county) (State) Florence N. Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11072 CERTIFICATE OF DEATH

REG. NO.

68-11072

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Degener, Henry Peter		2. DATE AND HOUR OF DEATH October 31, 1968 5:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 21-02	
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1300 James St.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-89	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Fritz Degener				14. MOTHER'S MAIDEN NAME Lena Boulkert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-2232		17. INFORMANT Elsie Degener, 1300 James St.	
18. 567.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA + GASTROINTESTINAL HEMORRAGE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA + GASTROINTESTINAL HEMORRAGE	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 578 X II				(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 16 19 68 to Oct. 31 19 68 , that (I) (we) last saw the deceased alive on 5:40 P.M., Oct. 31, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyung K. Lee, M.D.				23B. DATE SIGNED 11/1/1968	
23C. PHYSICIAN'S NAME (Type) Hyung K. Lee, M.D.				23D. ADDRESS 100 N. Calhoun St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/1968		24C. NAME OF CEMETERY OR CREMATORY Landon Park Cem.	
24D. LOCATION Baltimore, Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR John Cowan, Jr., 901 Hollins St. Balt. Md.	

THE NEW YORK

LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11073 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11073

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		M. CAROLINE COE		OCTOBER 31, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 LONG GREEN NURSING HOME				MARYLAND	
				C. CITY OR TOWN	
				BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3 E. 33rd. STREET	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT. 17, 1895	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PRINCIPAL		SCHOOL		PENNSYLVANIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
CYRUS WATERS COE			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		220-44-4215		T MISS ELIZABETH A. CONNELLY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Atherosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
440.9 I				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1968 to 1968, that (I) (we) last saw the deceased alive on 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. WILLIAM HELFRICH				11-1-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		5006 ROLAND AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-2-68		DRUID RIDGE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 6 1968		Mitchell Wiedefeld		MITCHELL WIEDEFELD HOME BALTO., MD	

Not a member

Let us be

W. B. H. T. X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11074 CERTIFICATE OF DEATH

REG. NO. 68-11074

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Malone Clyde G.		2. DATE AND HOUR OF DEATH 11/2/68 9 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 13-03		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2331 McCulloh Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-06	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Benjamin Malone		14. MOTHER'S MAIDEN NAME Ellen V.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214094113		17. INFORMANT (Wife) Bernice Malone - 2331 McCulloh Street	
18. 192.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Resp. arrest Coma today (B) CNS metastases DUE TO, OR AS A CONSEQUENCE OF: (C) Metastatic Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. 193.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/2/68 to 11/2/68 , that (I) (we) last saw the deceased alive on 11/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Seiden Muth MD		23B. DATE SIGNED 11/3/68		23C. PHYSICIAN'S NAME (Type) Bretz MD	
23D. ADDRESS 550 N. Broadway		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968	
25B. NAME OF REGISTRAR Kelso F. H.		25C. FUNERAL DIRECTOR 1348 N. Calhoun Street		25D. ADDRESS 1348 N. Calhoun Street	

V. 1001

no. 1001

ETTERDA'S

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FUNERAL DIRECTOR: IMPORTANT

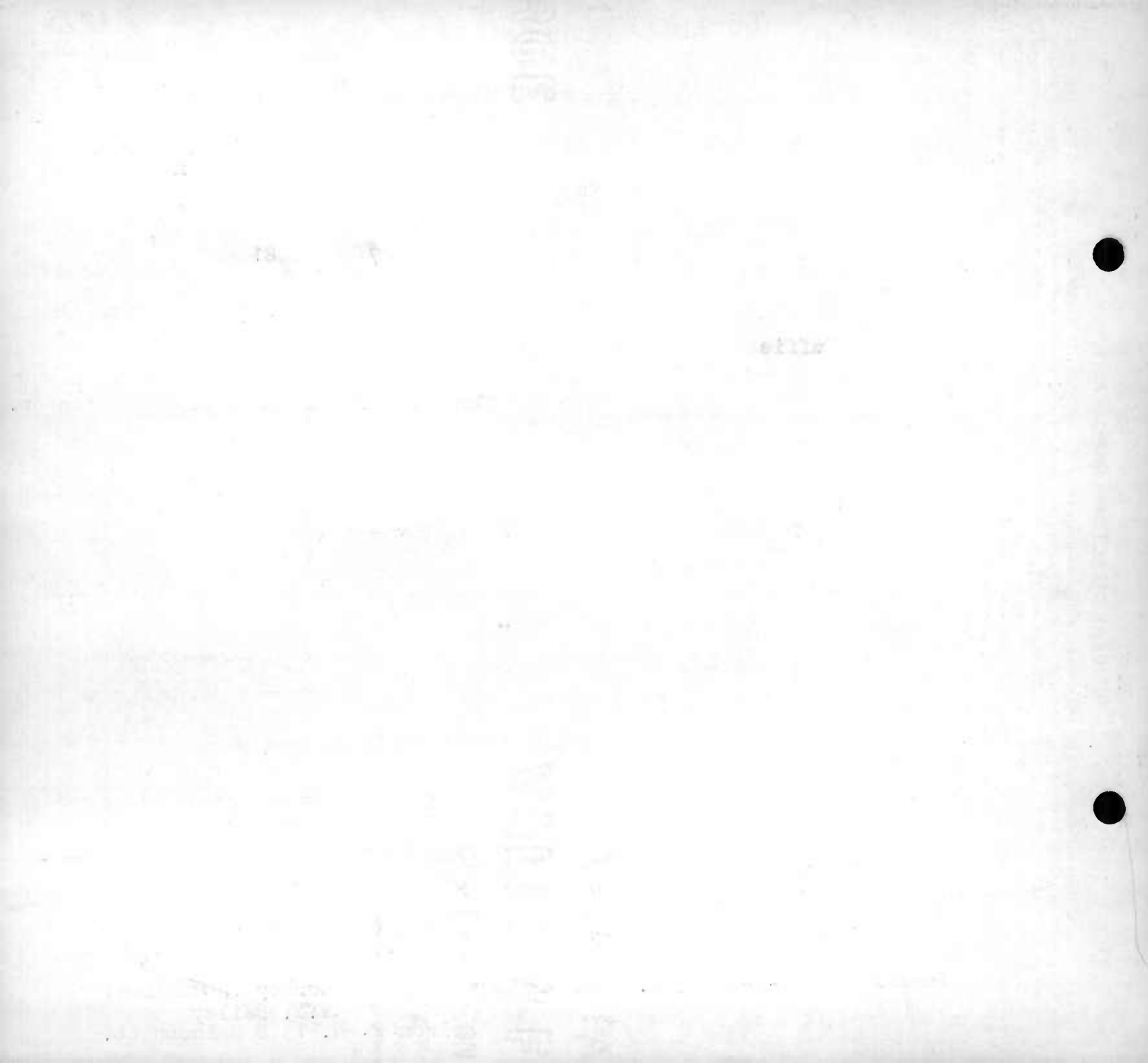
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11075 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11075

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BRIGGS JOSEPHINE		2. DATE AND HOUR OF DEATH NOV-3-68 5:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 16-07		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1501 DUKELAND ST.		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-87	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daffie			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence Briggs 2237 W. Lexington St.	
18. 038.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) BACTEREMIA DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 053.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV-3 1968 to NOV-3 1968 , that (I) (we) last saw the deceased alive on NOV-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George E. Garcia</i> JORGE E. GARCIA				23B. DATE SIGNED NOV-3-68	
23C. PHYSICIAN'S NAME (Type) JORGE E. GARCIA				23D. ADDRESS LUTHERAN HOSPITAL OF MD.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-68		24C. NAME OF CEMETERY or CREMATORY St. Rest Cemetery	
24D. LOCATION (City, town, or county) (State) Dorsey, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR 102.62.352.44		25C. FUNERAL DIRECTOR V.R. Bailey Kelson F. H. 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11076 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11076

BIRTH NO. <u>THOMPSON</u>		1. NAME OF DECEASED (Type or Print) <u>Thompson, Heiter</u>		2. DATE AND HOUR OF DEATH <u>10/31/68</u> <u>6.40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> E. STREET AND NUMBER <u>2416 Presbury St.</u>		
5. SEX <u>Female</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-75</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Ma.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Samuel Young</u>			14. MOTHER'S MAIDEN NAME <u>Fannie Emory</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mildred Ford</u> ADDRESS <u>same</u>		
18. <u>286.5</u> <u>II</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYPOSPHYTICISM</u> <u>UNDERNUTRITION</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHOPNEUMONIA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>HYPOSPHYTICISM</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>UNDERNUTRITION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 months</u> <u>6 months</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1</u> <u>1968</u> to <u>Oct 31</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>10/31/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Ruiz-Mora</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>11-4-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>
24D. LOCATION (City, town, or county) <u>Arbutus, Maryland</u>			24E. STATE (State) <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 6 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>V.R. Bailey</u> ADDRESS <u>Kelson F.H. 1348 N. Calhoun Street</u>	

R-300

68-11077 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11077

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

THELMA RODDY

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

October 31, 1968

6:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

October 31, 1968

6:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

New Jersey

V-27

6. SEX

Female

7. RACE

Negro

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Long Branch

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2-23-25

10. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1343 Joline Avenue-Monmouth, N.J.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Parris Jones

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Joseph Campbell

same

19. CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Fatty Metamorphosis of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-7-68

24C. NAME of CEMETERY or CREMATORY

White Ridge Cemetery - Eatontown, N.J.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

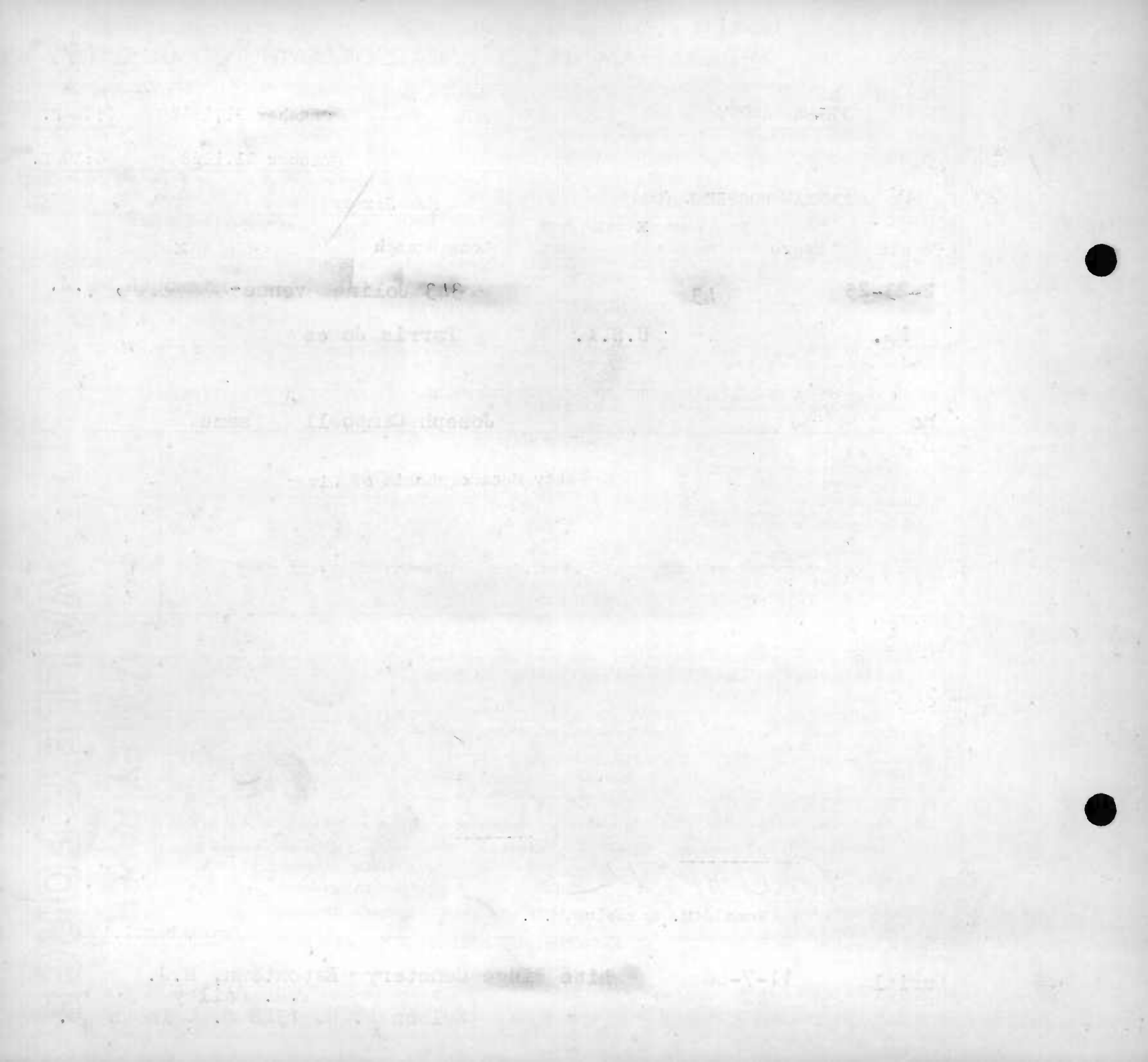
25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

V.R. Bailey

Kelson F. H. 1348 N. Calhoun St.



FUNERAL DIRECTOR: IMPORTANT

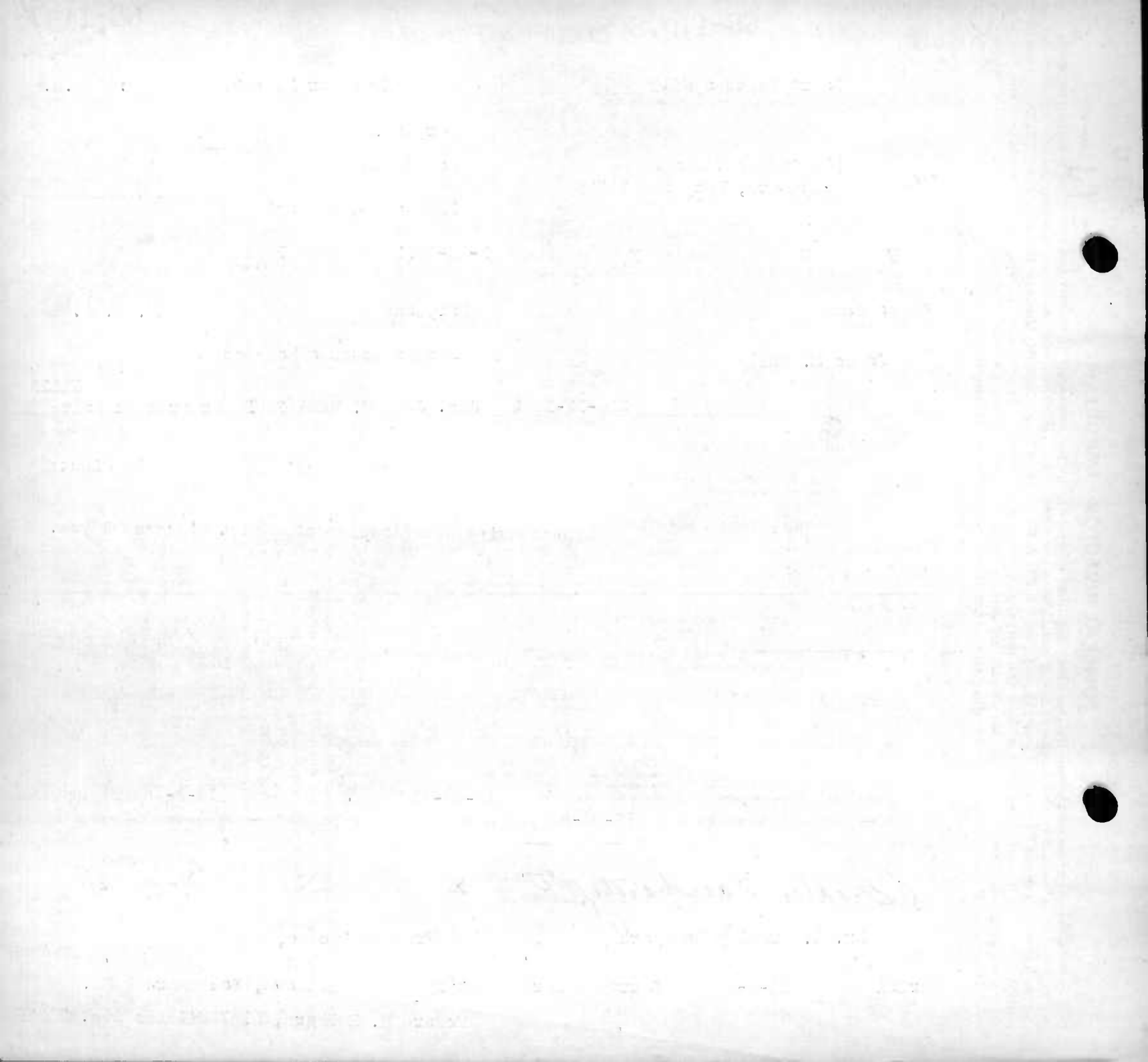
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11078 CERTIFICATE OF DEATH

REG. NO.

68-11078

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Laura Rebecca Hill		November 3, 1968 8:30 p.m. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 338 Oaklee Village Baltimore, Maryland 21229				A. STATE Maryland	
				C. CITY OR TOWN Baltimore	
15. SEX F				16. RACE W	
				17. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Companion				Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
James M. Kelly				Amelia Rebecca Magness	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-32-3986		Sgt. John W. Hill 3805 Margaret St Balto 21225	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>Coronary Occlusion</u> 30 minute					
(B) <u>Hypertensive Arteriosclerotic Heart Disease</u> 3 yrs.					
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>10-29-63</u> 19 to <u>11-3-68</u> 19, that (I) (we) last saw the deceased alive on <u>10-28-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Dr. A. Bradley Daugharthy</u>				<u>11-4-68</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. A. Bradley Daugharthy				1264 Francis Avenue,	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-6-68		Lorraine Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 6 1968		<u>Robert E. Hubbard</u>		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11079

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Early Ellwood Marvin Chambers

2. DATE
OF
DEATHKnown ☐ Estimated ☒Month
Day
Year11
2
1968Hour
Minute

2:40 PM

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE
PRONOUNCED DEADMonth
Day
Year11
2
1968Hour
Minute

3:00 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

M

7. RACE

C

B. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

11/8/37

10. AGE (In years lost birthday)

30

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

308 E. 27th street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Early Chambers

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lydia Booth

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

Lydia Chambers

ADDRESS

27 St Baet rd

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Gunshotwound of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

in front of 2218 Marris Street

22D. TIME OF INJURY (APPROX.)

11, 2, 1968 2:40 PM

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/3/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

11/9/68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

Robert E. [unclear]

25C. FUNERAL DIRECTOR

[unclear]

ADDRESS

2302 W North Ave Baltimore

James W. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11080

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JACOBS, Mr. Abraham		2. DATE AND HOUR OF DEATH Nov. 2, 1968 6.15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 Church Home and Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2322 E. Balto St. (234)		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-84	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Beth MD.	
13. FATHER'S NAME Morris Jacobs			12. CITIZEN OF WHAT COUNTRY? American U.S.A.		
14. MOTHER'S MAIDEN NAME Anna Stearns.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 215-03-8144		17. INFORMANT ADDRESS Anna Jacobs 2322 E. Balto St. (31)			
18. CAUSE OF DEATH 402 X I					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory failure					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.H.V.D.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 444 X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-19 1968 to 11-2 1968 , that (I) (we) last saw the deceased alive on 11-2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose F. Mier Jr.				23B. DATE SIGNED 11-2-68	
23C. PHYSICIAN'S NAME (Type) Jose F. Mier Jr.				23D. ADDRESS 100 N. BROADWAY CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-3-68		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH	
24D. LOCATION BALTIMORE, Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 6 1968			
25A. NAME OF REGISTRAR Robert E. Fuchsman		25B. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

45

23

2

between 1000 and 1100

Dear Sir

I am sorry to hear

that you are

Yours truly

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1A-165

68-11081

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68-11081

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lena Abrams

2. DATE AND HOUR OF DEATH

November 3rd 1968 5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore 53-00

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6906 BLANCHE RD

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12/3/1890

9. AGE (In years last birthday)

77

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Bloom

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

215 07 78 55

17. INFORMANT

ADDRESS

MRS. REVA GUTIN, 6906 BLANCHE ROAD #21215

18. 440.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Dehydration
secondary due to
Generalized Atherosclerosis

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

several months.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 2nd 1968 to November 3rd 1968, that (I) (we) last saw the deceased alive on November 3rd 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael G. ...

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/3/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

MARYLAND GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11-5-68

24C. NAME of CEMETERY or CREMATORY

HEBREW YOUNG MEN

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

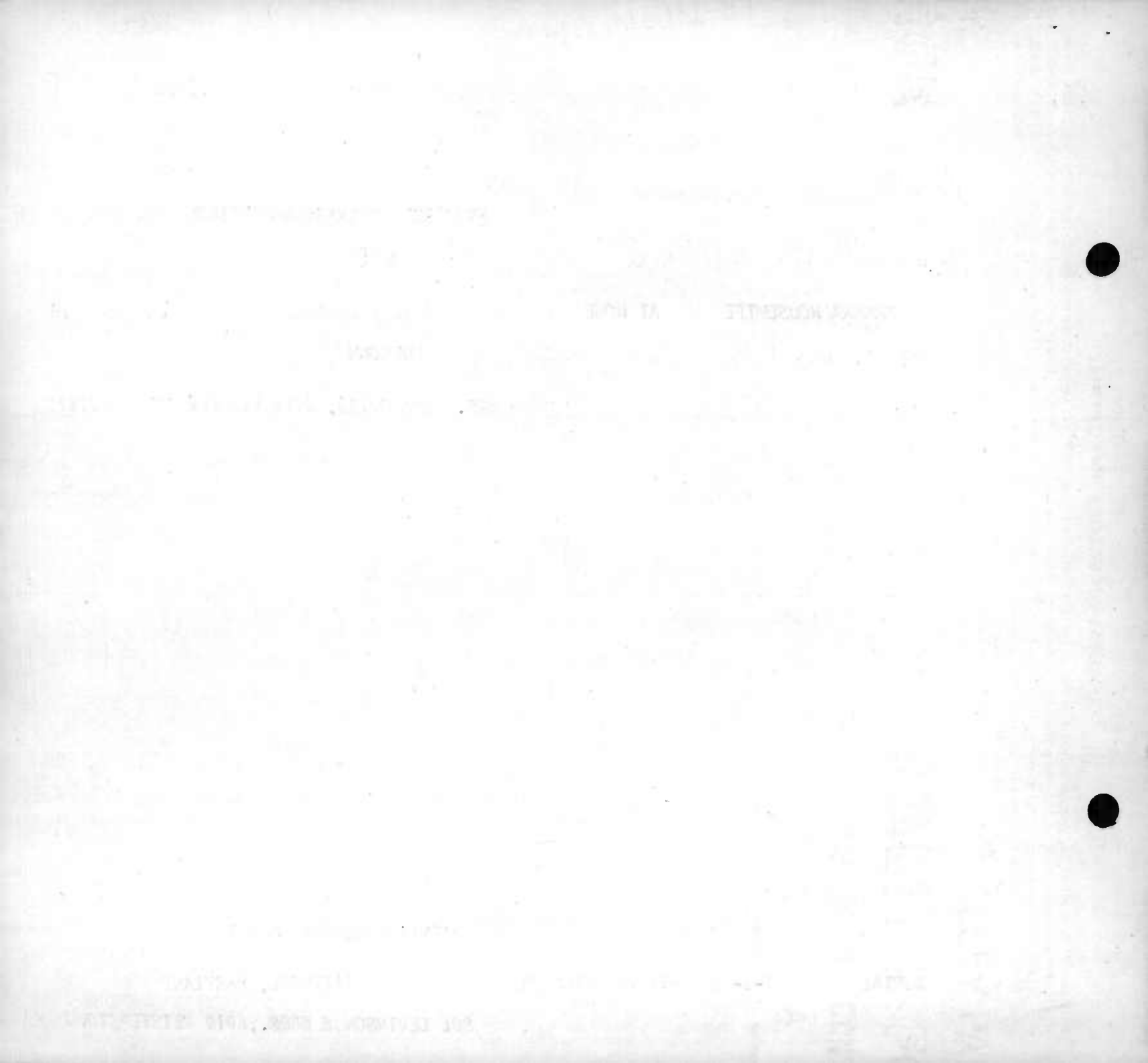
25B. NAME OF REGISTRAR

Robert E. ...

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

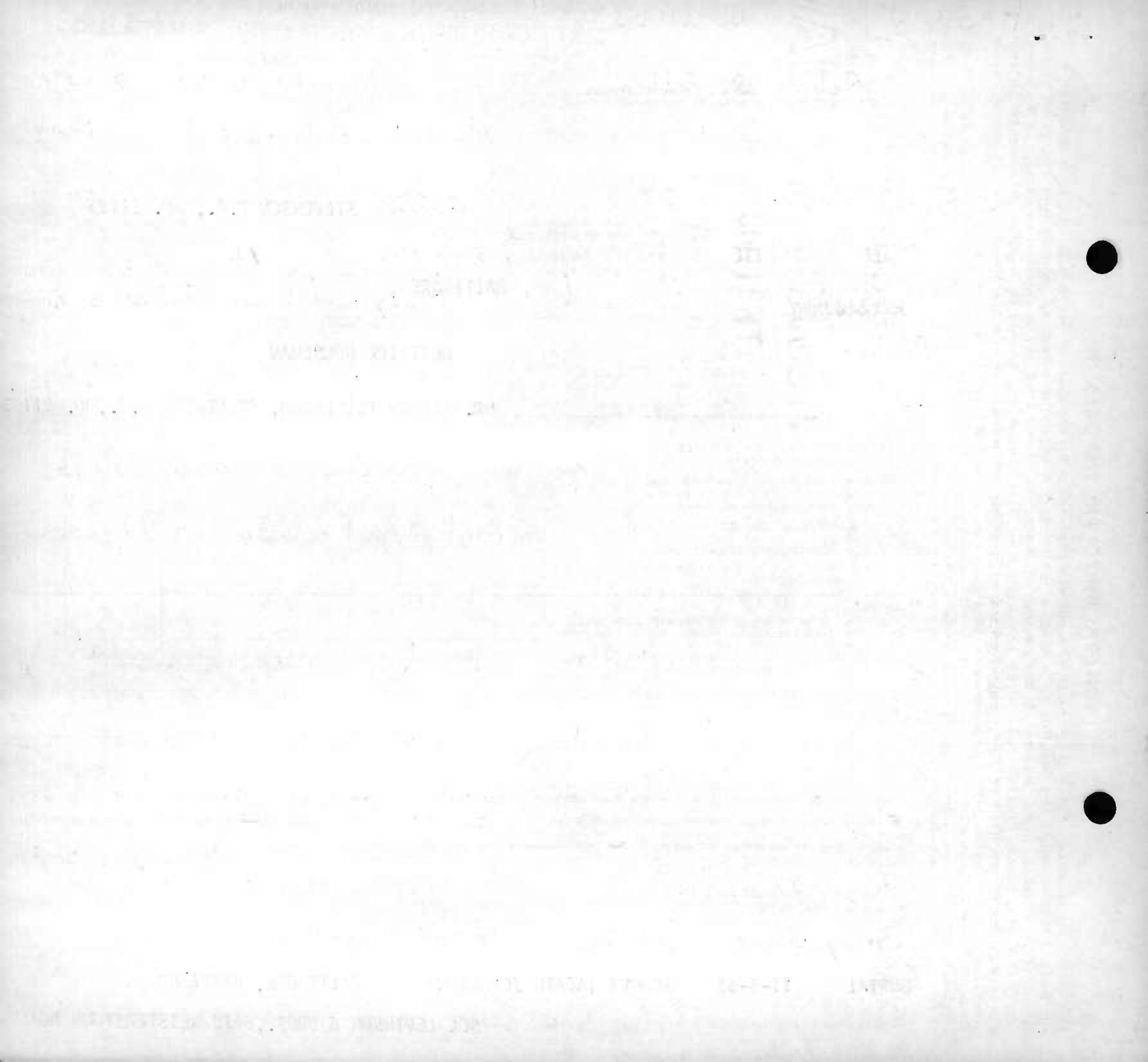
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11082			
1. NAME OF DECEASED (Type or Print) Robert Fedderman				2. DATE AND HOUR OF DEATH November 4, 1968 7:30 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore, Inc.				C. CITY OR TOWN				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER STEVENSON P.O., MD. 21153							
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/56		9. AGE (In years last birthday) 12		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (State or foreign country) BALTIMORE Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reuben Fedderman				14. MOTHER'S MAIDEN NAME BEATRICE HOUSEMAN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MR. REUBEN FEDDERMAN, STEVENSON P.O., MD. 21153				ADDRESS	
18. 315X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) mental & physical retardation DUE TO, OR AS A CONSEQUENCE OF: 12 years (C) ...				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days			
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from October 26, 1968 to November 4, 1968, that (I) (we) last saw the deceased alive on November 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Barry Green, M.D.				DEGREE				23B. DATE SIGNED 11/4/68			
23C. PHYSICIAN'S NAME (Type) Barry Green, M.D.				DEGREE				23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY SODOVA (ADATH JESHURON)				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968				25B. NAME OF REGISTRAR R. E. ...				25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11083

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11083

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLARD B. DAVIS		OCT 31, 1968 4:22 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
UNIVERSITY OF MD. HOSPITAL				MD. PRINCE GEORGES CO.	
				C. CITY OR TOWN D. INSIDE CITY LIMITS	
				JESSOP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
				BOX 38, RTE #1-52-00	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
♂	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/1/23	45	U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ENGINEER		—		MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DANIEL CHURCH			LILLIE DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 2				WIFE SAME	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				10 MIN.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				12 HRS	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY ARREST					
(B) GROSS HEMOPTYSIS DUE TO, OR AS A CONSEQUENCE OF:					
(C) CA (R) LUNG				? MOS	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 30 19 68 to OCT 31 19 68, that (I) (we) last saw the deceased alive on OCT 31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael J. Deegan Jr. M.D.				10/30/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				UNIV. OF MARYLAND HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-4-68		Baltimore National., Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 6 1968		Robert E. Snowden		Robert E. Snowden	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11084 CERTIFICATE OF DEATH

REG. NO. 68-11084

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STACHOWIAK MRS. DORIS G.		2. DATE AND HOUR OF DEATH Nov. 1st. 1968 11.20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 53.00	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 9406 Philadelphia Rd. (06)	
5. SEX Female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11.26.1928	9. AGE (In years last birthday) 39 years
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Andrew Przybylski				14. MOTHER'S MAIDEN NAME Bernice Jasinski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-5476		17. INFORMANT Louis Stachowiak	
				ADDRESS Same as Rev	
18. 582X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary edema (B) Uremia sec. to Chronic DUE TO, OR AS A CONSEQUENCE OF: Renal disease (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 592X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-27 1968 to 11-1 1968 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Mier Sr. M.D. DEGREE				23B. DATE SIGNED NOV. 1 '68	
23C. PHYSICIAN'S NAME (Type) Jose MIER SR. M.D. DEGREE				23D. ADDRESS Church Home & Hosp 100 N. Broad	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Philip E. Gwach		25C. FUNERAL DIRECTOR ADDRESS 1211 Chesaco Ave.	

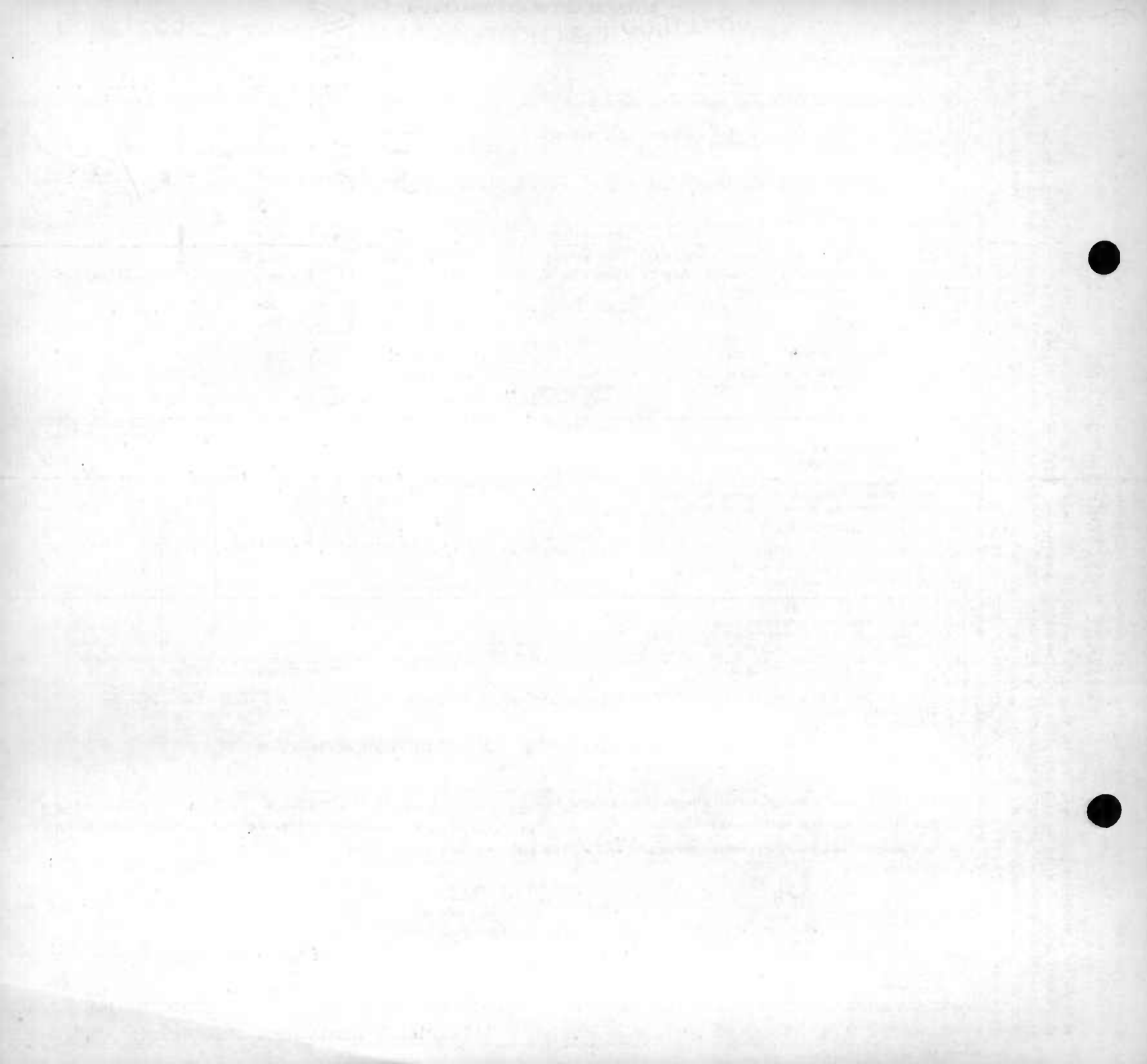
18-11-1902
Dear Sir,
I have the pleasure to
acknowledge the receipt of
your letter of the 11th inst.
and in reply to inform you
that the same has been
forwarded to the proper
authorities for their
consideration.
Yours faithfully,
J. H. [Signature]

Yours faithfully,
J. H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11085
BIRTH NO.		68-11085		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ADAM BRUCK		Nov. 2, 1968 3:15 P.M. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		A. STATE Maryland		
		B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2316 E. Eager St.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1912	9. AGE (In years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY State Roads Dept.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Bruck		14. MOTHER'S MAIDEN NAME Lena Hepp		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-5031		17. INFORMANT ADDRESS Mrs. Mary E. Bruck 2316 E. Eager St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes 3 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan 10, 1965 to Nov 2, 1968, that (I) (we) lost saw the deceased alive on Sept 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Joseph Pokorny M.D.		23B. DATE SIGNED Nov 4, 1968		
23C. PHYSICIAN'S NAME (Type) Joseph Pokorny, M.D.		23D. ADDRESS 2200 E. Madison St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery
				24D. LOCATION (City, town, or county) (State) Colgate, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11086

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Margaret E. Miller</u>		2. DATE AND HOUR OF DEATH <u>Nov. 2, 1968</u> <u>1:08 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u>			A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>26-02</u>
E. STREET AND NUMBER <u>4314 Sheldon Ave.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/96</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>ADAM FRANZ</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET MORAN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHESTER A. MILLER 4314 SHELDON</u>	
18. <u>5-19-2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Obstructive Pulmonary Disease</u> <u>5-27-2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <u>Cerebral Vascular Accident</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 13</u> 19 <u>68</u> to <u>Nov. 2</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>Nov. 2, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. CHARLES R. GOSHEN</u>				23D. ADDRESS <u>UNION MEMORIAL HOSP. BALTO. MD. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/5/68</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLY REDEEMER</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		24E. ADDRESS <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME 4210 BELAIR</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11087 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11087

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Andrew Karpewicz		2. DATE AND HOUR OF DEATH 11-2-68 110 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48				C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 624 S. Umbra St.					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-20	9. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10B. KIND OF BUSINESS OR INDUSTRY Gen. Motors		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph				14. MOTHER'S MAIDEN NAME Anastasia Balko	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 219-01532		17. INFORMANT Identification Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic disease				(B) DUE TO, OR AS A CONSEQUENCE OF: Lymphosarcoma	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None on this admission				(C) None	
19A. DATE OF OPERATION None on this admission		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/30 1968 to 11/2 1968 , that (I) (we) lost saw the deceased alive on 11/1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Sachs, MD				23B. DATE SIGNED 11-2-68	
23C. PHYSICIAN'S NAME (Type) MARVIN C. SACHS				23D. ADDRESS Horseshoe - Md. Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Nicholas T. Matthews	
				ADDRESS 3021 Eastern Ave., Baltimore, Md.	

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Mr. W. M. Driver
Gen. W. M. Driver
A. J. Driver
A. J. Driver
A. J. Driver

World War II
Caroling...
Medical...
Fighting...
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

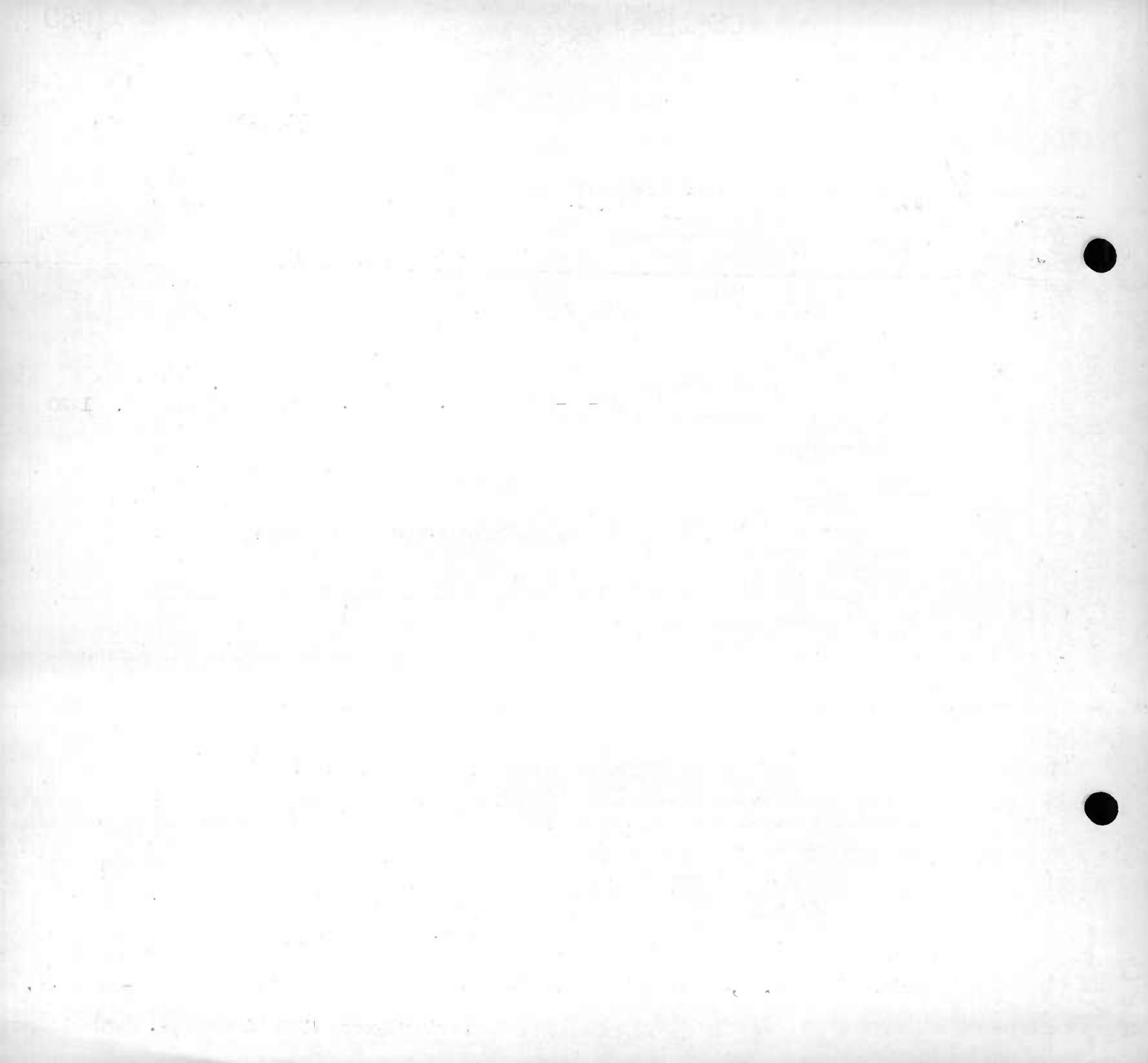
68-11088

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD Joseph CALVERT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 1, 1968 Hour 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2301 Cedley Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 2, 1968 4:30 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-19-1920 10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Calvert		E. STREET AND NUMBER 400 Lorrena Avenue (2301 Cedley St.)	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Mechanic		15. MOTHER'S MAIDEN NAME Elizabeth Stuart	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO. ?	
18. INFORMANT Mildred Calvert Balto., Md. 21230		ADDRESS 2301 Cedley Ave.	
19. 303.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Alcoholic Intoxication (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic Pancreatitis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/2/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1968	
24C. NAME of CEMETERY or CREMATORY Balto. Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. Balto., Md. 21202		ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11089
BIRTH NO. 68-11089		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) TIMANUS WILLIAM		2. DATE AND HOUR OF DEATH NOV 3-68 40.45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 363 GALLOWAY ROAD		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-15	9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALTO. TRANSIT CO.		10B. KIND OF BUSINESS OR INDUSTRY Bus Operator		11. BIRTHPLACE (State or foreign country) Baltimore County Maryland
13. FATHER'S NAME Percy Timanus		14. MOTHER'S MAIDEN NAME Lillian Henritz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-09-1510		17. INFORMANT Mrs. Ruby I. Timanus ADDRESS Rt. 15 Box 363 Galloway Rd. 21220
18. 198.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTASIS CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: 3 MONTHS (B) IN CEREBELLUM OR BRAIN STEM DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 193.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		20A. AUTOPSY? (Yes) <input checked="" type="checkbox"/> or No <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 9-29 1968 to 11-3 1968 , that (I) (we) last saw the deceased alive on 11-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23A. SIGNATURE [Signature] M.D. DEGREE		23B. DATE SIGNED 11-3-68		23C. PHYSICIAN'S NAME (Type) [Signature] M.D. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 7, 68		24C. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park
24D. LOCATION (City, town, or county) (State) Liberty Road Maryland-Balto Co.		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Loring Byers ADDRESS 8728 Liberty Rd. Randallstown		



THE BODY OF KATHERINE M. YOUNG HAS BEEN RELEASED AS NON MED BY DR BAS
OF THE MEDICAL EXAMINER'S OFFICE
THIS PATIENT WAS PRONOUNCED DEAD ON ARRIVAL AT CITY HOSPITAL 11-2-68
FUNERAL DIRECTOR. IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-520		68-11080		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11090	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) KATHERINE MARGARET YOUNG			
2. DATE AND HOUR OF DEATH 11-2-68 9:20 P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (DOA) THE BALTIMORE CITY HOSPITAL BALTIMORE, MD 21224			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-29-29 9. AGE (In years lost birthday) 39				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ANTHONY MCDONALD				14. MOTHER'S MAIDEN NAME MARGARET HOARN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 196-22-3897			
17. INFORMANT (Husband) Frederick D. Young Jr. 7511 Lawrence Rd.				ADDRESS Dundalk, Md.			
18. 396.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 410X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 25 Sept 1968 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral Commission 20A. AUTOPSY (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes CAUSE OF DEATH Rheumatic heart disease - Mitral Stenosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: - Triptid - antit regurgt. 2 yrs - CHF - Embolism (B) DUE TO, OR AS A CONSEQUENCE OF: history of pulmonary embolism 1 year Arrhythmia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21D. TIME OF INJURY (APPROX.)				21E. HOW DID INJURY OCCUR?			
21F. HOW DID INJURY OCCUR?				21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from November 19 67 to October 19 68, that (I) (we) last saw the deceased alive on October 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.				23A. SIGNATURE Dr. J. O. Humphries / Dr. Dagenais			
23B. DATE SIGNED Nov 3-68				23C. PHYSICIAN'S NAME (Type) DR GILLES DAGENAIS M.D. JOHNS HOPKINS HOSPITAL, BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/6/68			
24C. NAME OF CEMETERY or CREMATORY Western Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968				25B. NAME OF REGISTRAR Robert E. Sisk			
25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.							

[illegible]

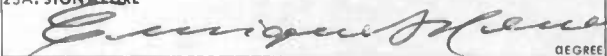
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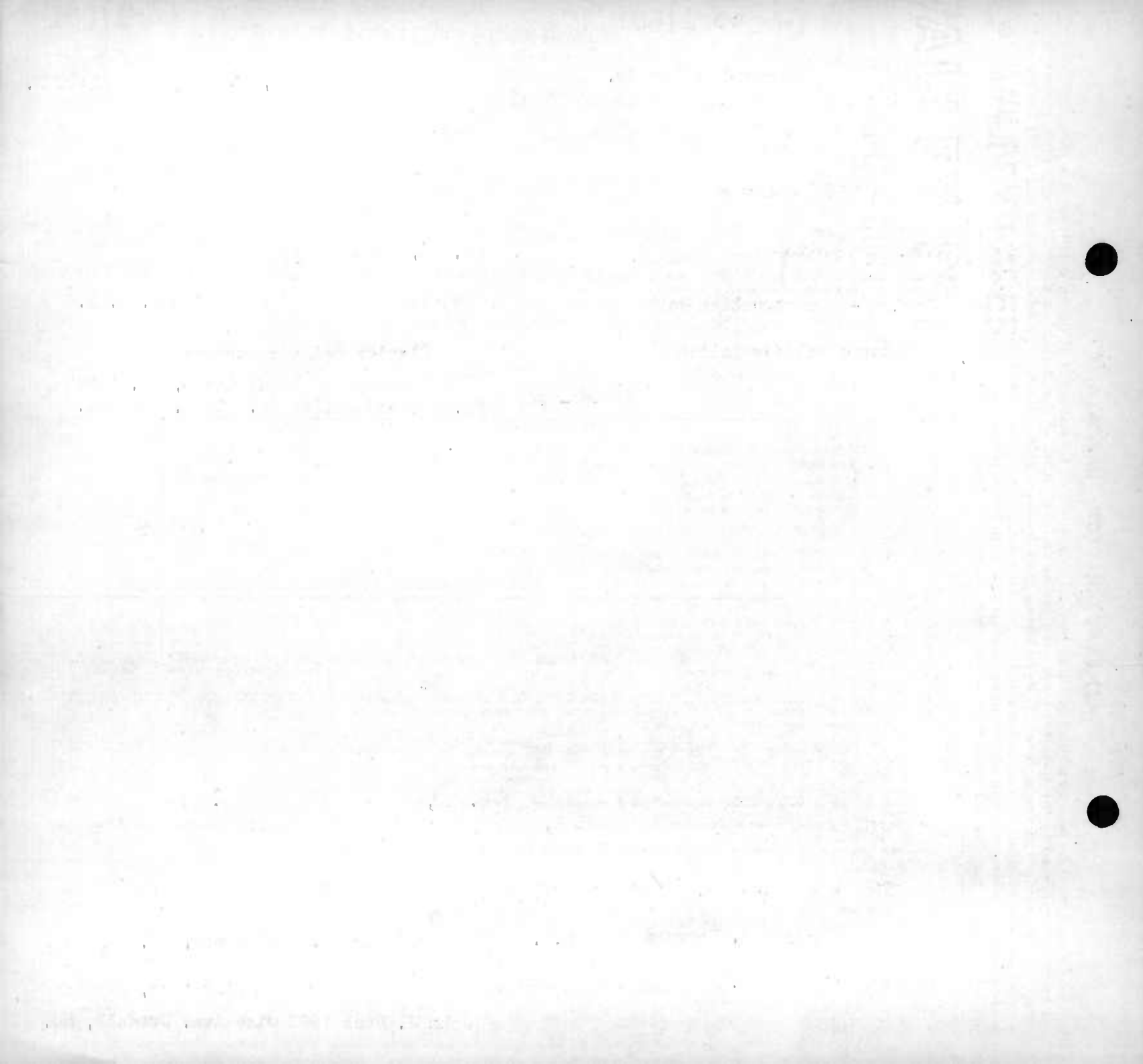
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25-5-1947

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11091 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-11091	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Raymond Tallon Sr.		November 1, 1968 1:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Maryland		
00 3548 Juneway			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3548 Juneway		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1898	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Construction Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Spain	
13. FATHER'S NAME Ricardo Salgade Tallon		14. MOTHER'S MAIDEN NAME Placida Reigada Gardosa			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-3967		17. INFORMANT (Son) Baltimore, Md. 21224 Mr. Raymond Tallon Jr. 525 S. 45th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY-ARTERY DISEASE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) was examined attended the deceased from Feb. 22, 1961 to Nov. 1, 1968, that (I) was lost saw the deceased alive on Oct 7, 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was examined view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 11/1/68	
23C. PHYSICIAN'S NAME (Type) Enrique A. Herrera M.D.				23D. ADDRESS 1001 Dundalk Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/68		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 6 1968			
25A. NAME OF REGISTRAR John J. Duda		25B. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

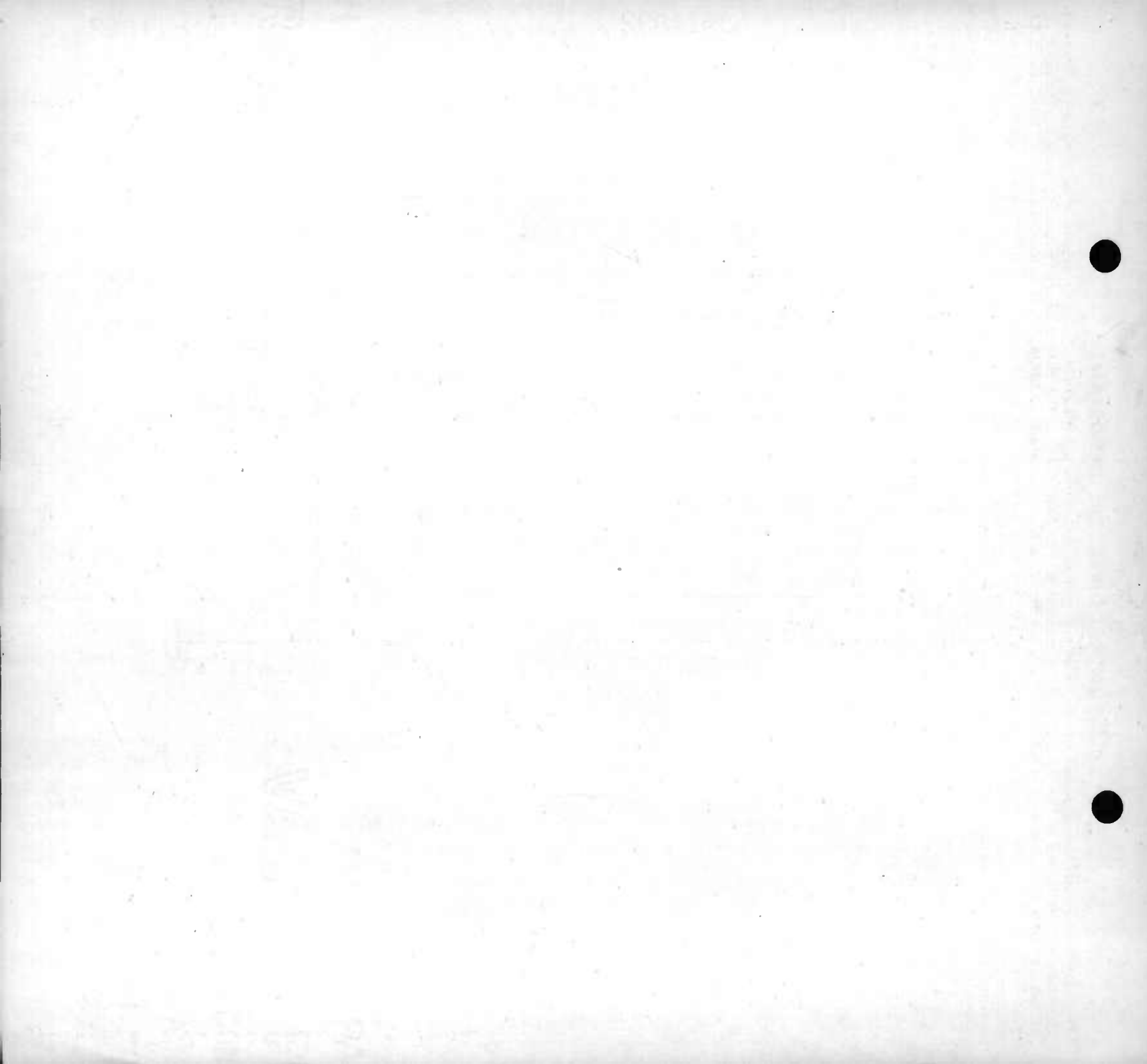
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11092

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11092

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Harry M. R. Heneour</i>		2. DATE AND HOUR OF DEATH <i>11/1/68 6:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
5. SEX <i>Male</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/16/02</i> 9. AGE (In years last birthday) <i>66</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>		11. BIRTHPLACE (State or foreign country) <i>Md?</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>216-12-8862</i>		17. INFORMANT <i>Dr. Samorodin - University Hospital</i> ADDRESS	
18. <i>4019</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>1 day</i>			
ANTECEDENT CAUSES		(B) <i>ASUVD</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>—</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) <i>420.1 II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (H) (this hospital) attended the deceased from <i>11/1/68</i> 19 <i>68</i> to <i>11/1</i> 19 <i>68</i> , that (H) (we) lost saw the deceased alive on <i>6:00 PM 11/1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles Samorodin M.D.</i> DEGREE				23B. DATE SIGNED <i>11/1/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles Samorodin</i> DEGREE				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/5/1968</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Acre Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Greenwood, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 6 1968</i>			
25B. NAME OF REGISTRAR <i>Charles E. Eubank</i>		25C. FUNERAL DIRECTOR <i>John J. Conner, Inc. Inc 901 Hollins St. Green. Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11093 CERTIFICATE OF DEATH

REG. NO.

68-11093

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDNA M. PFEIFER		2. DATE AND HOUR OF DEATH NOVEMBER 3, 1968 8³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1210 WASHINGTON BLVD			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-89	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Housewife		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JOHN WOERNER		
14. MOTHER'S MAIDEN NAME MARY ELLEN SPENCER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212-07-5437			17. INFORMANT ADDRESS HOSPITAL CHART.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 152.04-250.9			CAUSE OF DEATH Respiratory arrest.		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of duodenum, 2 metastases to brain, lungs, liver & peritoneum		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 152.0 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 25 1968 to November 3 1968 , that (I) (we) lost saw the deceased alive on November 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond Gambrell 3rd M.D.				23B. DATE SIGNED 11-3-68	
23C. PHYSICIAN'S NAME (Type) Raymond Gambrell 3rd, M.D.				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 6 '68		24C. NAME OF CEMETERY or CREMATORY Meadow Ridge Cemetery	
24D. LOCATION Dorsey Rd. Howard Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968			
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

DATE 10/1/82 BY SP-5 JWS

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOSEPH NEMEHECK				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> November 2, 1968 4:30 A.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour November 2, 1968 6:03 A.M.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00			
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10-5-1876		10. AGE (In years lost birthday) 92		E. STREET AND NUMBER 632 Dunwich Way			
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Nemecheck			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Anna Jambrick			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 105-26-5900		18. INFORMANT Harmon Funeral Home, 571 Forest Ave. New York		ADDRESS Staton Isl.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/2/68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1968		24C. NAME of CEMETERY or CREMATORY St. Peters Cemetery		24D. LOCATION (City, town, or county) (State) Staton Island, New York	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

WALLLEY JOHN

— [Signature] —

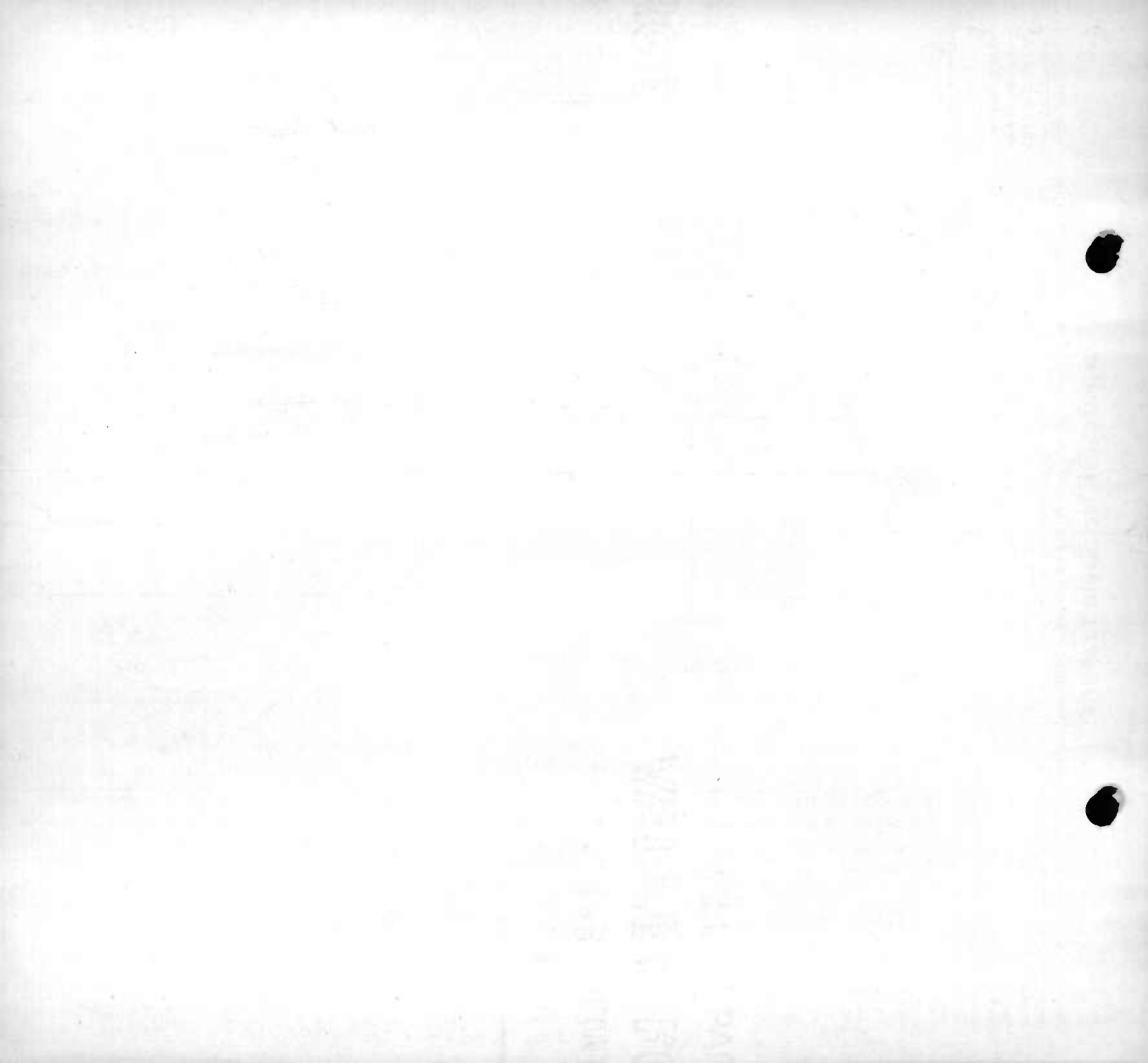
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11095 CERTIFICATE OF DEATH

REG. NO. 68-11095

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Emmalee Kerns</i>		2. DATE AND HOUR OF DEATH <i>11:30 pm 10-31-68</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore Md.</i>		A. STATE <i>Baltimore</i>		B. COUNTY <i>53-00</i>	
C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <i>21220</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-8-25</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Oakland Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Carl Liller</i>				14. MOTHER'S MAIDEN NAME <i>Elve Clayton</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-24-9356</i>		17. INFORMANT <i>Susan Royal</i>		ADDRESS <i>550 Compass Rd Balto</i>	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				CAUSE OF DEATH <i>(Dementia) CVA</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic cerebral disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>carcinoma of lungs.</i> (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 months</i>			
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10-31-68 11:30 AM</i> 19 to <i>10-31-68 11:45 PM</i> 19, that (I) (we) last saw the deceased alive on <i>10-31-68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Gian Caggiano M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-31-68 11:45</i>	
23C. PHYSICIAN'S NAME (Type) <i>GIAN CAGGIANO</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/3/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Pleasant Valley Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Garrett County, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Gerald N. Minnich</i>		ADDRESS <i>Oakland Maryland</i>	



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68-11096 BALTIMORE CITY HEALTH DEPARTMENT

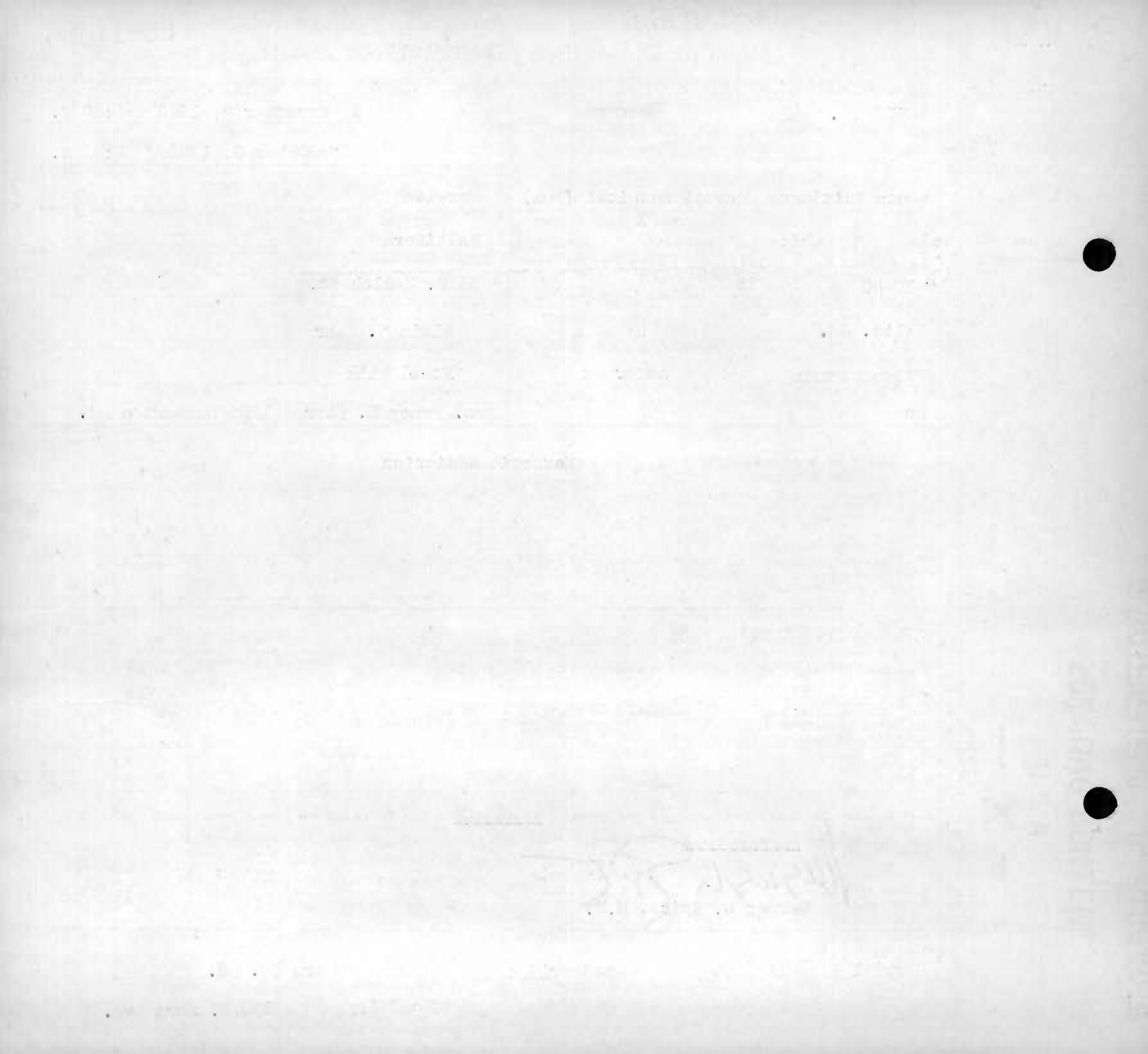
68-11096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

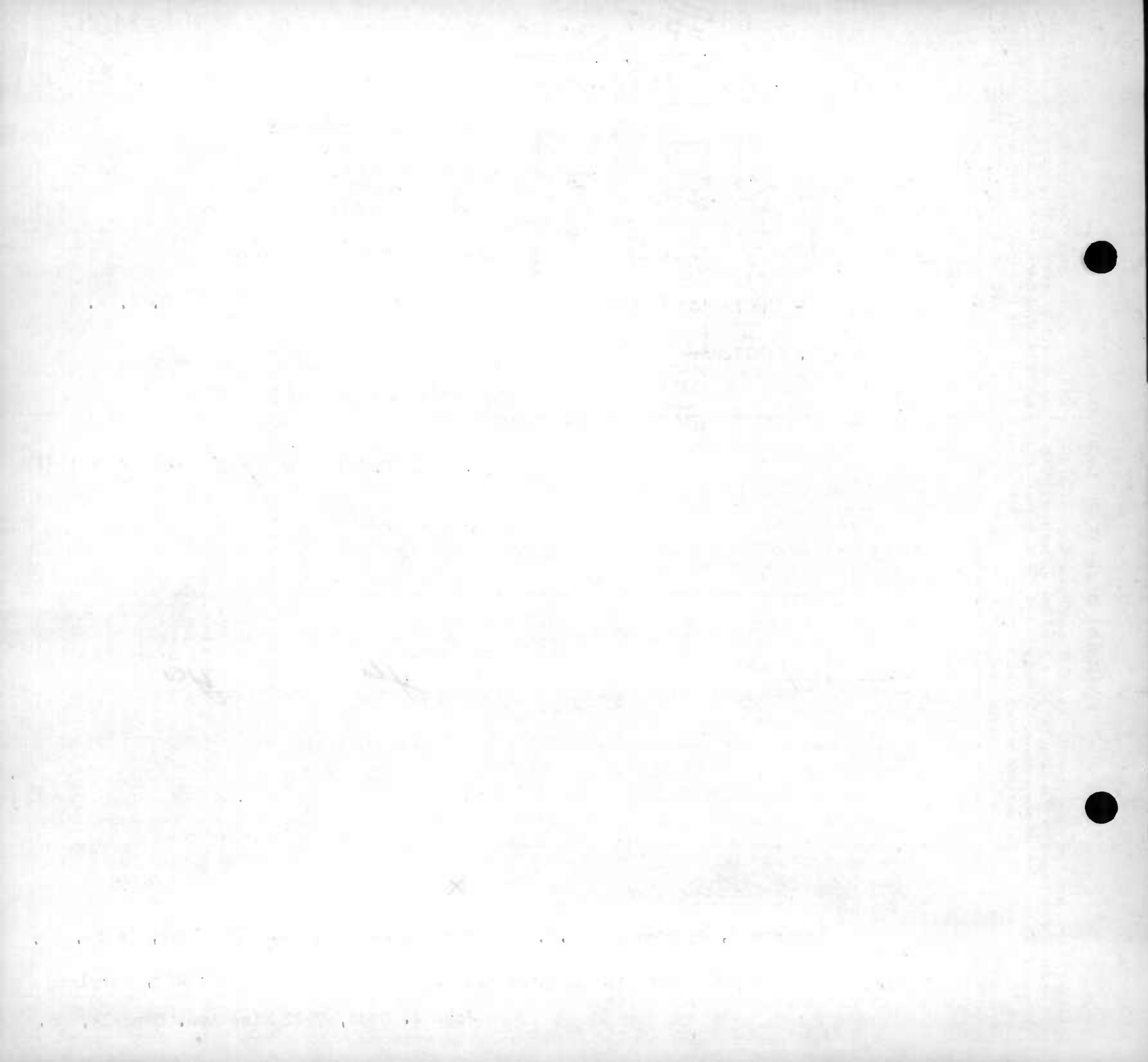
1. NAME OF DECEASED (Type or Print) ALVIN W. BAHR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 4, 1968 Hour 5:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 5, 1968 Hour 2:05 A. M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10 10 40		10. AGE (in years last birthday) 28	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		14B. KIND OF BUSINESS OR INDUSTRY Beverage	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Nancy L. Bahr		ADDRESS 1026 Dumbarton Rd.	
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Narcotic Addiction		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 11 8 68		24C. NAME OF CEMETERY or CREMATORY Meadowridge	
24D. LOCATION (City, town, or county) (State) Howard Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Mc Cully	
25D. ADDRESS 130 E. Fort Ave.		25E. DATE SIGNED 11/5/68	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11097
BIRTH NO. 68-11097		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Raymond P. Schlipper		2. DATE AND HOUR OF DEATH Nov 4, 1968 11 ³⁰ A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles Gen Hosp. 2724 N. Charles St.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Baltimore Co C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4 SEABRIGHT Ave		
5. SEX Male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-02	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - The Martin Company		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME August G. Schlipper		
14. MOTHER'S MAIDEN NAME Grace Brannen		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		
16. SOCIAL SECURITY NO. 213-01-2657		17. INFORMANT ADDRESS HOSPITAL CHART		
18. 1-5-3-3 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca of Liver 3-4 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) See of record DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 1-5-3-3 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/25 1964 to Nov 4 1968 , that (I) (we) lost saw the deceased alive on Nov 2 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Theodore J. Graziano		23B. DATE SIGNED 11/4/68		23C. PHYSICIAN'S NAME (Type) Theodore J. Graziano M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/7/68		24C. NAME of CEMETERY or CREMATORY Bel Air Memorial Gardens
24D. LOCATION (City, town, or county) Bel Air, Maryland		24E. STATE (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR R. J. ...		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11098

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11098

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MABEL JEAN DUNKERLY

2. DATE AND HOUR OF DEATH

NOVEMBER 1, 1968 1:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

Anne Arundel Co 52-00

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

454 Old Quarterfield Road Apt 5

5. SEX

FE

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-11-1946

9. AGE (In years lost birthday)

21

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Billing Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Montgomery Ward

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MAX HERMAN GREGOR

14. MOTHER'S MAIDEN NAME

CONAWAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214-46-0788

17. INFORMANT

Pls Chart

ADDRESS

18.

63291

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Irreversible shock

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 hours

(B) Pelvic and retroperitoneal hemorrhage DUE TO, OR AS A CONSEQUENCE OF:

7 hours

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

3-10-31-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Pregnancy: Molar hemorrhage

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-30-1968 to Nov. 1-1968, that (I) (we) last saw the deceased alive on Nov. 1-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Virgil C. Supetran

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-1-68

23C. PHYSICIAN'S NAME (Type)

Virgil C. SUPETRAN

DEGREE

23D. ADDRESS

Bon Secours Hosp. 2025 N. Fayette St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/4/68

24C. NAME OF CEMETERY or CREMATORY

Mendowridge Memorial Park

24D. LOCATION

E/K Ridge

(City, town, or county)

(State)

md

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

John E. Jackson

25C. FUNERAL DIRECTOR

R.V. Singleton / Glen Burnie, Md.

ADDRESS

College of Business Administration

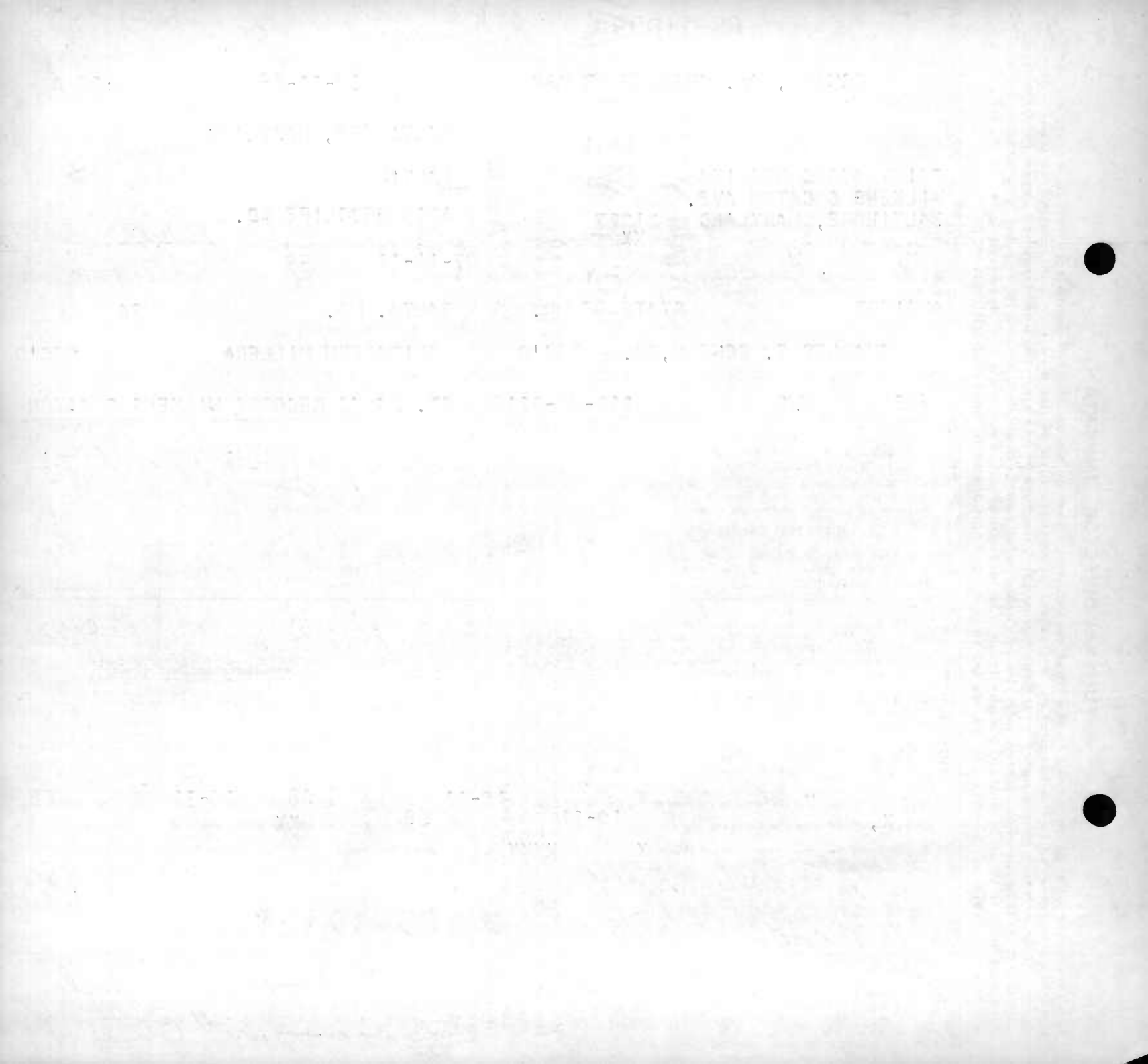
Page 10

Business Administration
University of North Carolina

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>5-500 68-11099 CERTIFICATE OF DEATH REG. NO. 68-11099</p>	
<p>BIRTH NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) SCHEMM, JR. CHARLES EDWARD</p>	
<p>2. DATE AND HOUR OF DEATH 10-31-68 8:30 A M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY</p>	
<p>5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 07-14-13 9. AGE (In years last birthday) 55</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR</p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY STATE OF MD.</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTO. MD.</p>	
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME CHARLES E. SCHEMM, SR. DEC'D</p>	
<p>14. MOTHER'S MAIDEN NAME ELIZABETH MILLER DEC'D</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2</p>	
<p>16. SOCIAL SECURITY NO. 212-09-7316</p>	
<p>17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON</p>	
<p>18. CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.4 I Coronary arteriosclerosis 5 yrs</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II Cirrhosis of Liver 3 yrs</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from 10-31 19 68 to 10-31 19 68, that (X) (we) last saw the deceased alive on 10-31 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.</p>	
<p>23A. SIGNATURE Earl Pass MD 23B. DATE SIGNED 10-31-68</p>	
<p>23C. PHYSICIAN'S NAME (Type) E. EARL PASS 23D. ADDRESS 4001 Wilkens Ave</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11-2-68 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem. 24D. LOCATION (City, town, or county) (State) Woodlawn Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968 25B. NAME OF REGISTRAR Robert S. Jenkins 25C. FUNERAL DIRECTOR ADDRESS Forly, Catherine B. H. Cottrill, Md</p>	



FUNERAL DIRECTOR: IMPORTANT

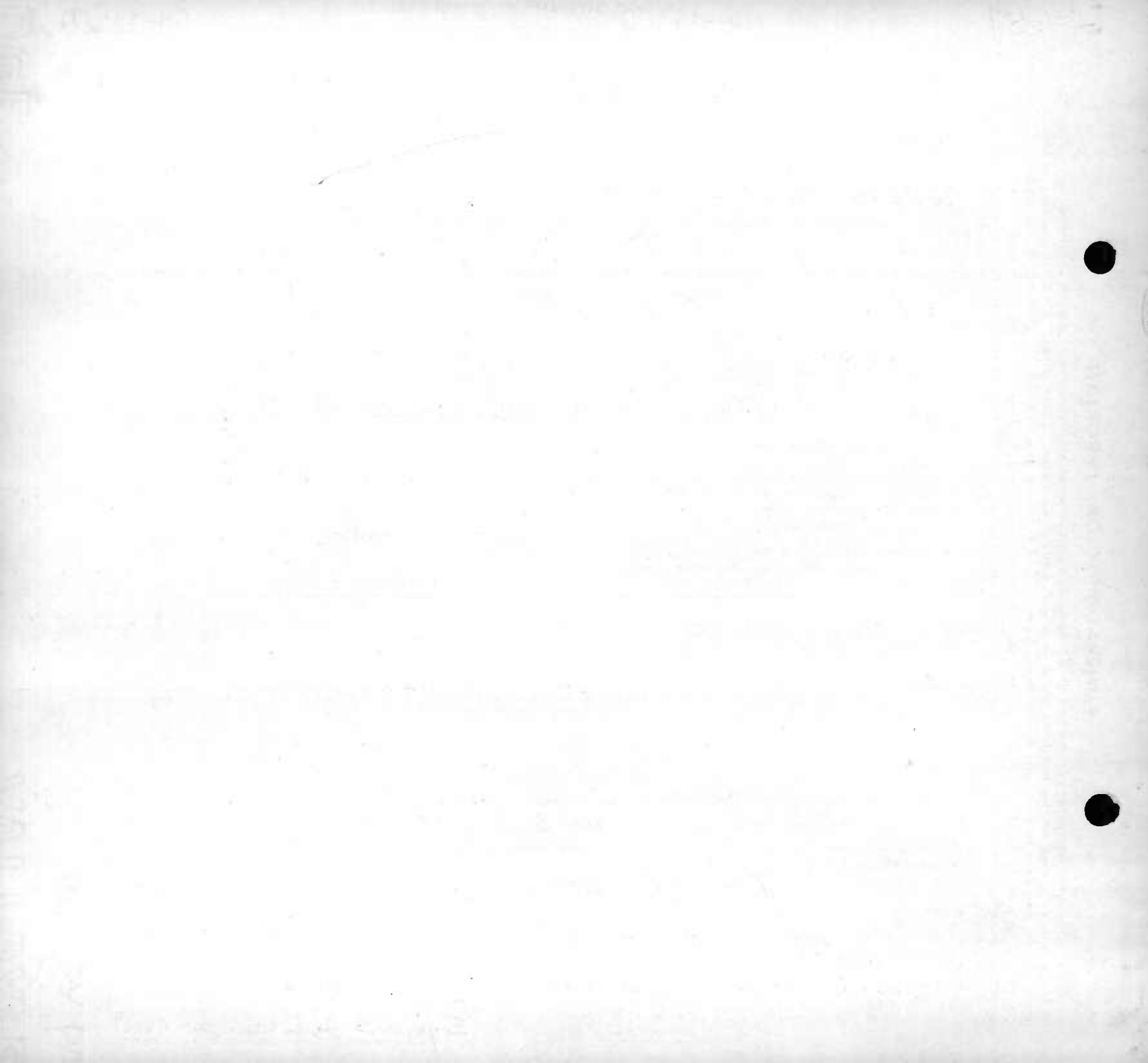
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11100

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68-11100

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GREENBERG, JOEL J.		2. DATE AND HOUR OF DEATH 11-3-68 6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4256 LABYRINTH RD.
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-19	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) E. J. KORVETTE		10B. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mat		14. MOTHER'S MAIDEN NAME Jeanette	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 215-07-6310		17. INFORMANT Mrs Ella Greenberg	
18. ADDRESS Same		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 II		(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-2-68 19 to 11-3- 19 68 , that (I) (we) last saw the deceased alive on 11-3- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge Garcia MD		23B. DATE SIGNED 11-3-68		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> DEGREE	
23C. PHYSICIAN'S NAME (Type) JORGE GARCIA MD		23D. ADDRESS LUTHERAN HOSPITAL OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/5/68	24C. NAME OF CEMETERY or CREMATORY Crofton Emment City Chain		24D. LOCATION (City, town, or county) (State) Balta MD	
25A. DATE RECEIVED BY HEALTH DEPT. 11/5/68		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvanus S. Lewis & Son, INC - 9610 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11101

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH Della Moore		2. DATE AND HOUR OF DEATH 11/3/68 3:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Wicomico Co 72-00			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 22 Greene Street BALTIMORE MD		C. CITY OR TOWN Del MAR		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 100 PINE ST					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-51	9. AGE (In years last birthday) 17	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME C. Edmund ENNIS		14. MOTHER'S MAIDEN NAME Madeline DOWNES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Yes		17. INFORMANT ADDRESS MR. RICHARD A. MOORE See Sec. 4	
18. 590.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pseudomonas Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
(B) chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF:		(C) Chronic Bleuraphritis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 600.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/1/68 to 11/1/68 , that (I) (we) last saw the deceased alive on 11/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ellis S Caplan MD				23B. DATE SIGNED 11-3-1968	
23C. PHYSICIAN'S NAME (Type) ELLIS S. CAPLAN				23D. ADDRESS Univ Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-6-1968		24C. NAME of CEMETERY or CREMATORY Wicomico Memorial PARK	
24D. LOCATION SALISBURY, Wicomico. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Hill FUNERAL Home SALISBURY, MD Norman F. Baker			

Downes

House W 72

C. Elmy

Mr Richard A. Moore Sec

yes

yes

Ellis S. Caplan

BURIAL 11-4-1964 William Pennine Park, Salisbury, Wiltshire
Hill Funerals, Salisbury

11-5-1964

NON MED - DR KORN BLUM
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-11102				CERTIFICATE OF DEATH		68-11102	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Waldman, EOGAR J.				2. DATE AND HOUR OF DEATH 10-31-68 3.45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				A. STATE Maryland			
				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 6200 Ferore Way 21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 02-19-92	9. AGE (In years lost birthday) 76 yrs.	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY Acme Food Store		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Waldman				14. MOTHER'S MAIDEN NAME Elizabeth Batchelor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-4819		17. INFORMANT Regina (nee Spence) Waldman, wife, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 198.5 I Metastatic CA Unknowns primary ?				INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 199.1 II Pathological FX L femur				5 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 199.1 II Retinal detachment of R eye.							
19A. DATE OF OPERATION 10/27/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Jew itt Nail L femur FX		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/8/68 19 to 10/31/68 19 that (I) (we) last saw the deceased alive on 10/31/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kevin N. Hennessey, M.D.				23B. DATE SIGNED 10/31/68			
23C. PHYSICIAN'S NAME (Type) Kevin N. Hennessey, M.D.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 2601 -03-05 E. Madison Street 21205	

Mr. J. M. Smith

WON WED - DE KORN BLIND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11103 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11103	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARIE CHAMBERS		2. DATE AND HOUR OF DEATH 11/1/68 11:17 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 33RD & CALVERT STS BALT. MD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7746 ELISON AVE			
5. SEX F	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/97	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Baumgartner		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 215-03-9509		16. SOCIAL SECURITY NO. 215-03-9509		17. INFORMANT ADDRESS Joseph M. Frank, son-in-law, above	
18. 712.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) RENAL FAILURE (C) RHEUMATOID ARTHRITIS			
19. 722.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/15 19 68 to 11/1 19 68 , that (I) (we) lost saw the deceased alive on 11/1 19 68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald M. Legum M.D.		23B. DATE SIGNED 11/1/68		23C. PHYSICIAN'S NAME (Type or Print) RONALD M. LEGUM M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/68		24C. NAME OF CEMETERY OR CREMATORY Baltimore, Md. Moreland Mem. Park.	
24D. LOCATION (City, town, or county) (State) 33RD & CALVERT STS BALT MD		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

11/11/51
JAN 1952

RECEIVED
JAN 1952

RECEIVED

MD
VSA

RHEUMATOID ARTHRITIS
GREAT FAULTS
PNEUMONIA

NO

11/11/51
11/11/51

MD
RECEIVED

RECEIVED
JAN 1952

RECEIVED
JAN 1952

RECEIVED
JAN 1952

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KAUFMAN

ANNA

Catherine

2. DATE AND HOUR OF DEATH

11/1/68

8:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Balt. City Hospitals

4940 EASTERN AVENUE

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2439 E. Lager St. 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7-20-1910

9. AGE (In years)

58

If Under 1 Yr.

Months

Days

Hours

Min.

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore
MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH SCHIMUNEK

14. MOTHER'S MAIDEN NAME

KATE

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-288545

17. INFORMANT

ADDRESS

RECORDS: BCH-4940 Eastern Avenue 21224

18. 250.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

SEPTICEMIA

PNEUMONIA, PNEUMONIA

(B) UNDERLYING CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

DIABETES MELLITUS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-28 1968 to 11-1 1968,
that (I) (we) last saw the deceased alive on 11-1-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Ralph Hyden

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

11/1/68

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/4/68

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

Ralph Hyden

25C. FUNERAL DIRECTOR

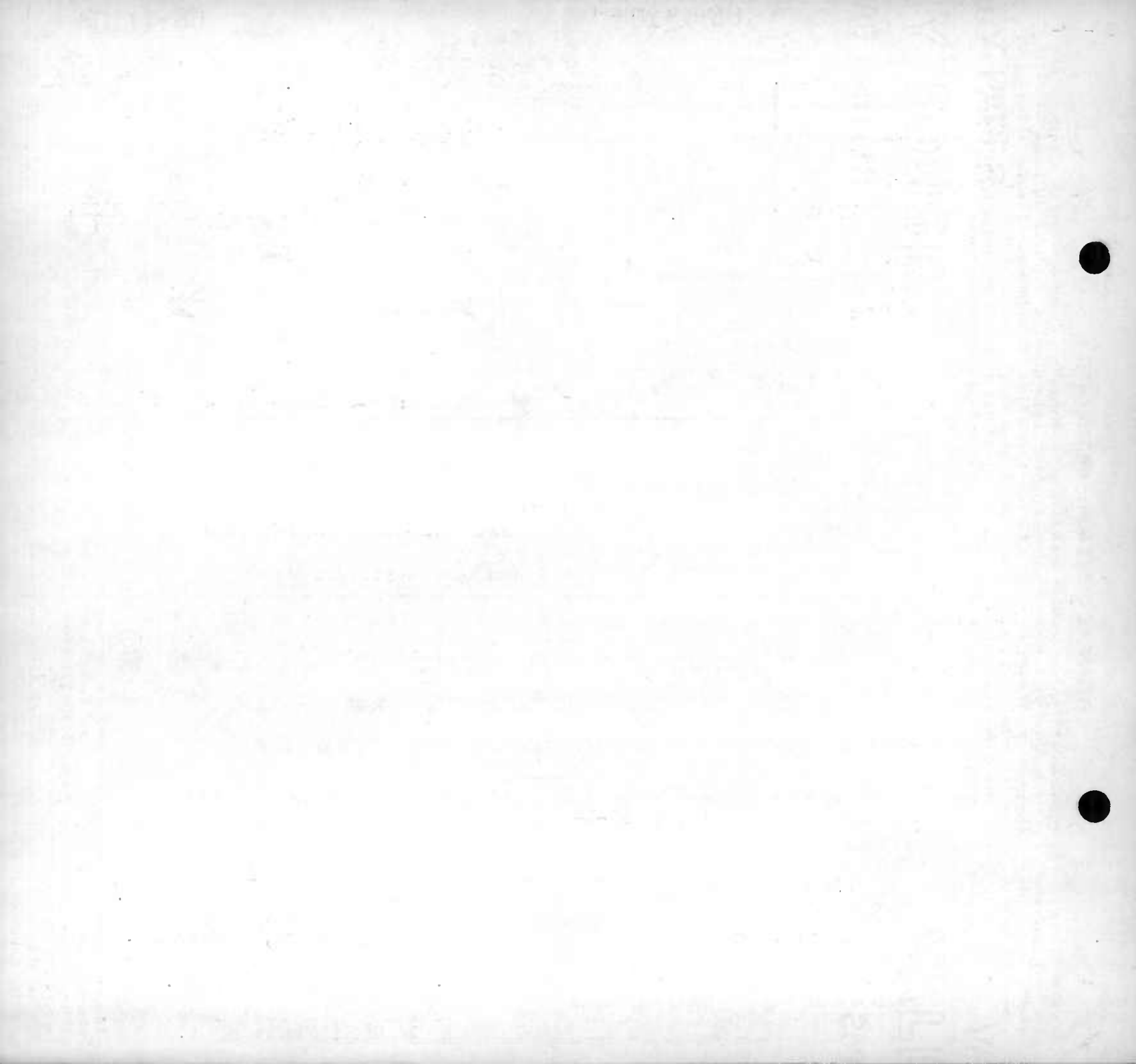
Schimunek Funeral Home, Inc.

ADDRESS

2600 E. Madison St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



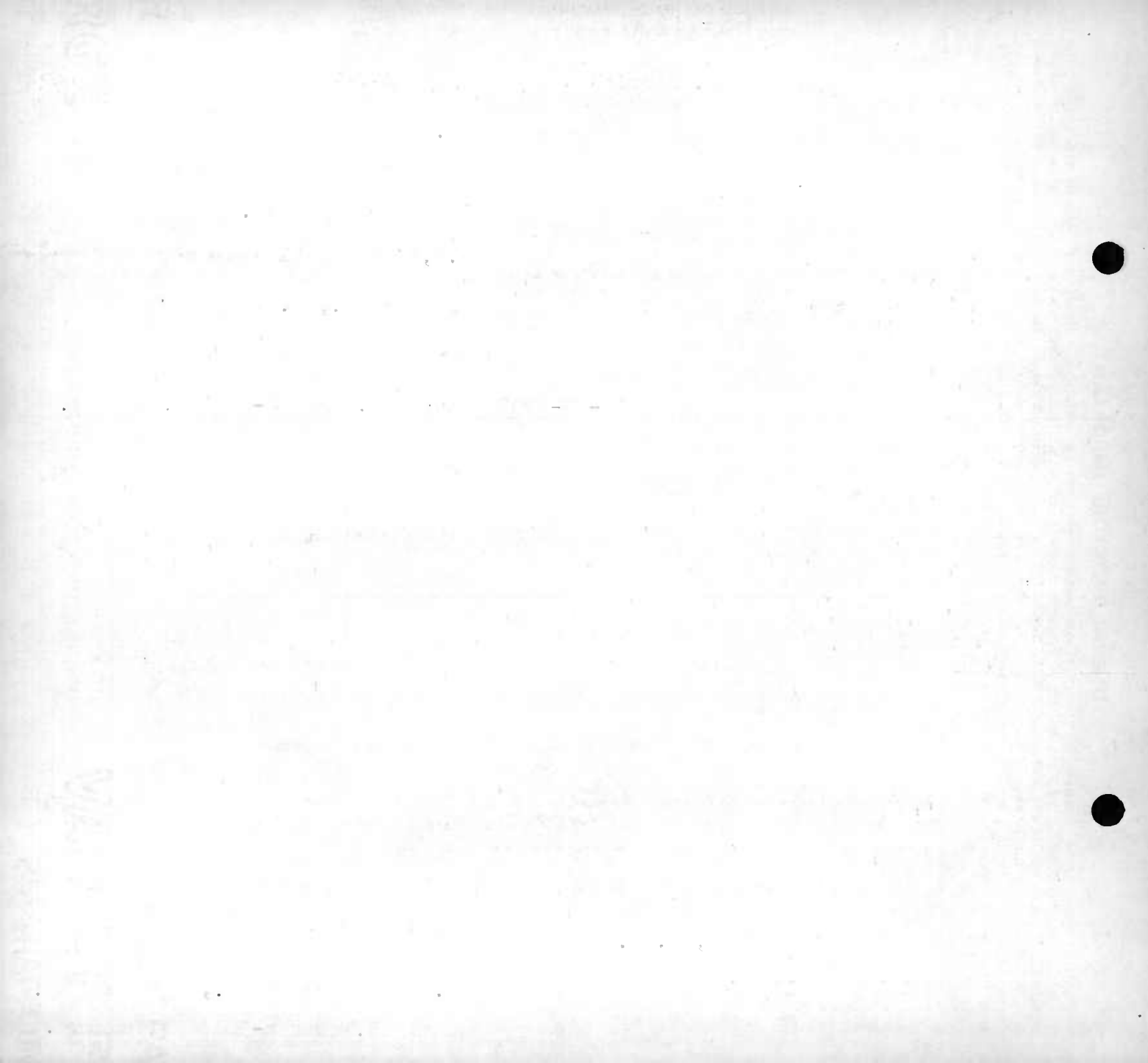
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11105 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11105

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charles J. Harnish		2. DATE AND HOUR OF DEATH 11-2-68 6:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3902 Mortimer Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1886	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Harnish		14. MOTHER'S MAIDEN NAME Laura Nusbaum	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-5209		17. INFORMANT ADDRESS Edward O. Harnish-1423 W. 41st St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC MYOCARDITIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN 1961		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEB. 11 1961 to NOV. 2 1968 , that (I) we lost saw the deceased alive on JULY 5 1968 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.					
23A. SIGNATURE Reuben Hoffman, M.D. OEGREE				23B. DATE SIGNED 11-3-68	
23C. PHYSICIAN'S NAME (Type) Reuben Hoffman, M.D. OEGREE				23D. ADDRESS 846 W. 36th St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/68		24C. NAME OF CEMETERY or CREMATORY Emmanuel Church Cem.	
24D. LOCATION (City, town, or county) Carroll Co.,		24E. STATE Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968	
25B. NAME OF REGISTRAR Michael E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Austin E. Donovan-3818 Roland Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

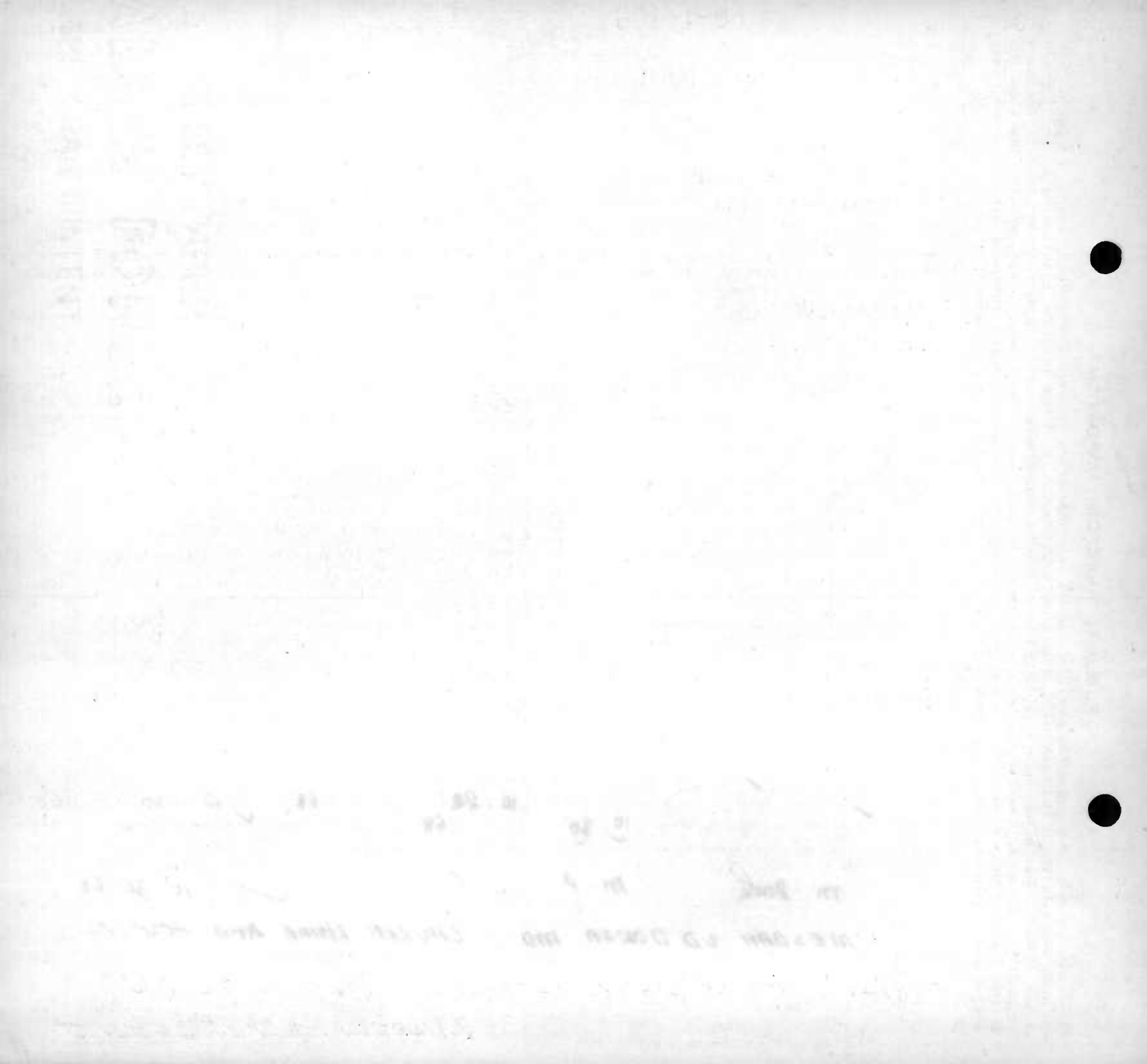
68-11106

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11106

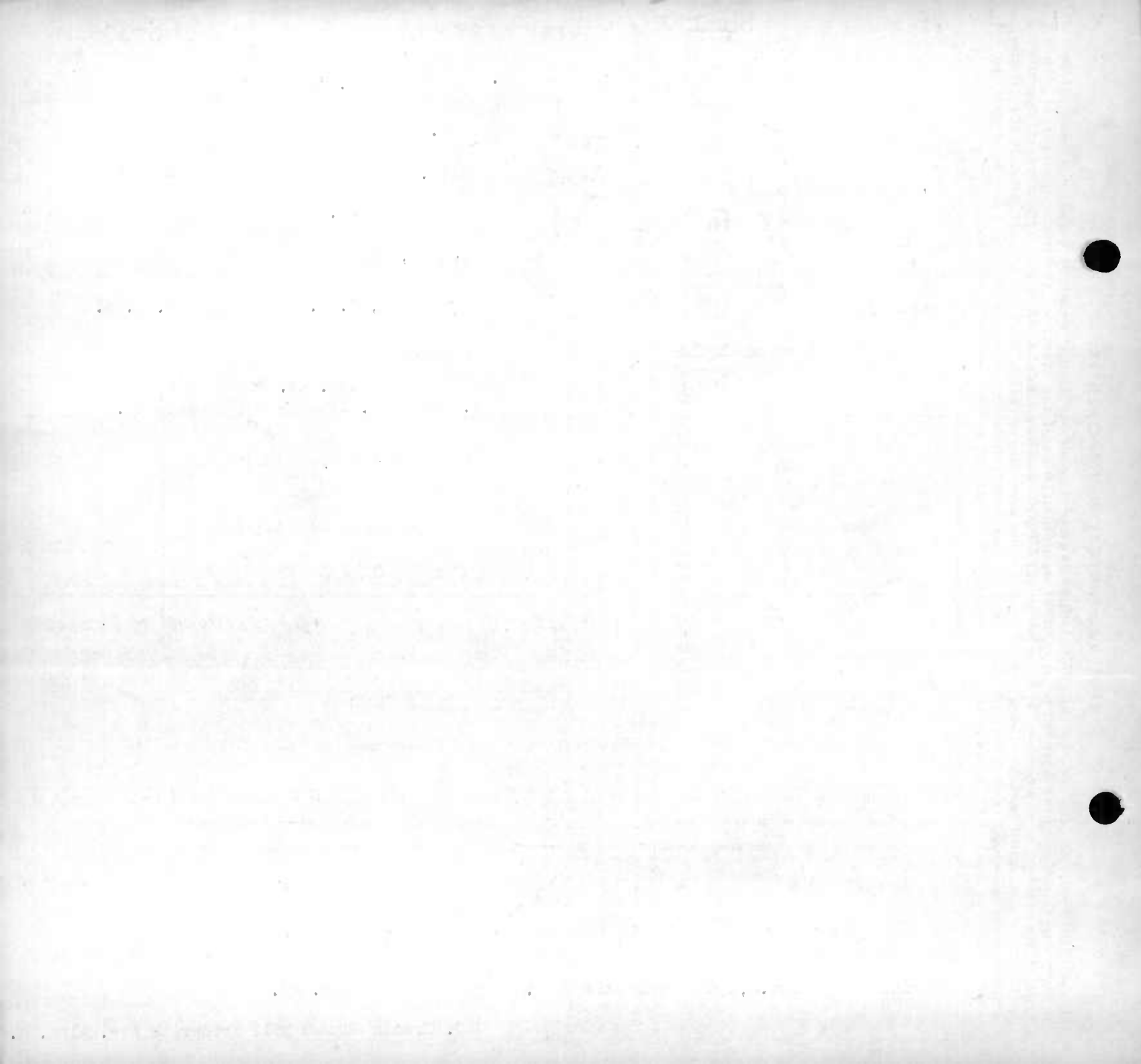
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Lillian Mulligan		2. DATE AND HOUR OF DEATH 10-30-68 12-15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hosp. 35 Baltimore Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 222 N. Kenwood Ave.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Charles Rockert			14. MOTHER'S MAIDEN NAME Mary Ritter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) - -		16. SOCIAL SECURITY NO. 213-202266	17. INFORMANT John H. Mulligan 222 N Kenwood Ave		
18. 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ch. Arterio sclerotic Heart disease Ch. Auricular Fibrillation Old - C.V.A.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-22-1968 to 10-30-1968, that (I) (we) last saw the deceased alive on 10-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE m. Dosh m. D			23B. DATE SIGNED 10-30-68		23C. PHYSICIAN'S NAME (Type) MESBAH VD DOWLA MD
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11-4-68		24C. NAME OF CEMETERY or CREMATORY BALTO. NATL. CEM.
24D. LOCATION BALTIMORE MD			25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR B. DABROWSKI 2818 F. BALTO. ST.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11107
BIRTH NO. 68-11107		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ALBAUGH ALICE W.		2. DATE AND HOUR OF DEATH Nov. 1, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 404 Edsdale Rd.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1892	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Clarence Snyder		
14. MOTHER'S MAIDEN NAME Unknowned		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT Balto. Md. 21229 Mr. Robert S. Albaugh 404 Edsdale Rd.		
18. 707.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE GRAM NEGATIVE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: (B) INFECTED DECUBITUS ULCERS DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC DEBILITATION		
19. 715 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10 - 26 - 1968 to 11 - 1 - 1968 , that (H) (we) last saw the deceased alive on 11 - 1 - 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Joseph Notarangelo M.D.		23B. DATE SIGNED NOV-1-1968		23C. ADDRESS MERCY HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 1968		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		
25B. NAME OF REGISTRAR G. Truman Schwab		25C. FUNERAL DIRECTOR 3512 Frederick Ave. Balto. Md.		



1
S-620

68-11108 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11108

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM SQUIRES

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 4, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

(BOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 4, 1968

8:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1465 Woodall Street

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM SQUIRES

14A. USUAL OCCUPATION (Give kind of work
done during most of working life. If retired)

Ship Fitter

14B. KIND OF BUSINESS OR INDUSTRY

Ship Yard

15. MOTHER'S MAIDEN NAME

MARY E. GEISLER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Amelia Squires 1465 Woodall St.

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11/8/68

24C. NAME of CEMETERY or CREMATORY

CEDAR HILL CEMETERY

24D. LOCATION (City, town, or county) (State)

GLEN BURNIE, MARYLAND

25A. DATE RECEIVED BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

Charles E. Squires

25C. FUNERAL DIRECTOR

McCully 130 E. Fort Ave.

Ship Fitter 2nd Class

WALTER E. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11109 CERTIFICATE OF DEATH				REG. NO. 68-11109	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret CRAVER</i>		2. DATE AND HOUR OF DEATH <i>11/1/68</i> <i>1206P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-11-06</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY -----		9. AGE (In years last birthday) <i>62</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Francis Marion Benson</i>			14. MOTHER'S MAIDEN NAME <i>Mary Virginia Crown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>412.31</i> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD ASHD</i>		
			(B) <i>Rheumatic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>life</i>		
			(C) <i>Acute Renal Failure</i> <i>2 weeks</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/1/68</i> to <i>11/1/68</i> , that (I) (we) last saw the deceased alive on <i>11/1/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert H. Brook M.D.</i>				23B. DATE SIGNED <i>11/1/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert H. Brook M.D.</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVE. BALTO. MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/4/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore Md.</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley, M.D.</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Balto. St.</i>	

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68-11110 BALTIMORE CITY HEALTH DEPARTMENT

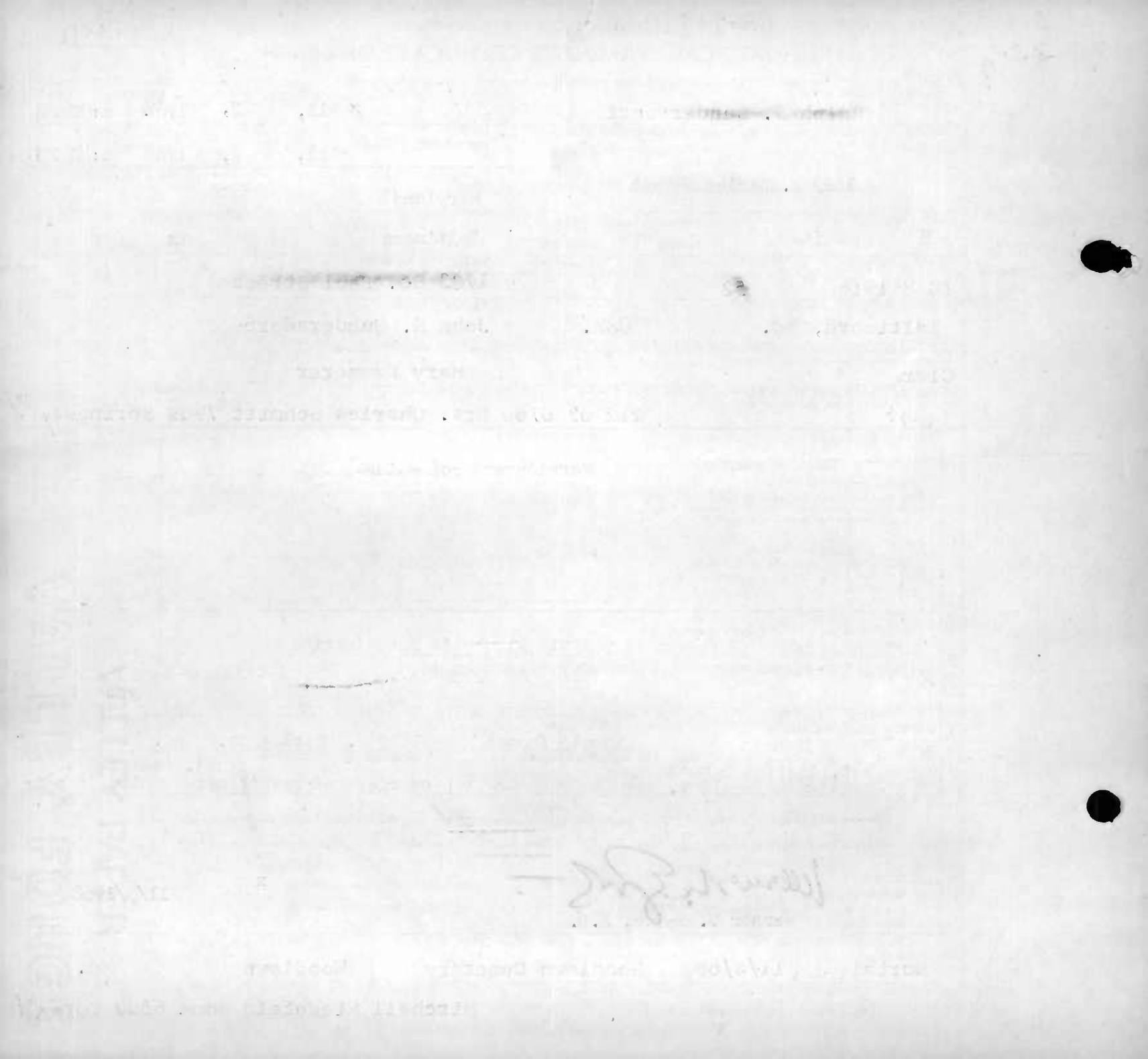
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11110

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ralph J. Gundersdorf				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 11, 2, 1968 6:00 PM			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1829 N. Charles Street				3. DATE PRONOUNCED DEAD Month Day Year Hour 11, 2, 1968 6:40 PM			
6. SEX M				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10 8 1916				10. AGE (Years lost birth) 52		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME John H. Gundersdorf		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-05	
15. MOTHER'S MAIDEN NAME Mary Kammerer				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 212 03 0700				18. INFORMANT Mrs. Charles Schmitt			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Barbiturate Poisoning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acute Alcoholic Intoxication				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hotel (home)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1829 N. Charles St. Apt. 12				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) bet 11/1/68 & noon 11/2/68 6:15 P.m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? subj. ingested an overdose of barbiturates while intoxicated.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 11/3/1968 EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR W. J. Spitz		25C. FUNERAL DIRECTOR Mitchell Wiedefeld			
ADDRESS 6500 York Rd							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11111				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11111	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) COLES, EDWARD E.				2. DATE AND HOUR OF DEATH 11/2/1968 11:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4618 SCHENLEY Rd.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-09-23	9. AGE (In years lost birthday) 45	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY Credit Mgr. Dept. Store		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME EDWARD E. COLES S.R.				14. MOTHER'S MAIDEN NAME EVELYN HARDING Burgess			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-9936 A		17. INFORMANT Miss Leah A. Coles		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163.0 I CAUSE OF DEATH (A) IMMEDIATE CAUSE EARCINOMA OF RIGHT PLEURAL LUNG DUE TO, OR AS A CONSEQUENCE OF: (B) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (C) ...				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 10-26 19 68 to 11-2 19 68 , that (I) was last saw the deceased alive on 11-2 19 68 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.							
23A. SIGNATURE Luis Lintado M.D.				23B. DATE SIGNED 11-2/1968			
23C. PHYSICIAN'S NAME (Type) Luis Lintado M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Paul E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.			

UNION MEMORIAL HOSPITAL

W X

rot

EDWARD ESCOBAR

EVELYN HARDING

URBANA

AMERICAN

10-09-83

W18 SCENE VIEW RD
BALTIMORE

NO. 1000

CARDIAC ARREST

EMERGENCY DEPARTMENT

Signature
11-5-83

10-5-83

11-5-83

UNITED STATES N.O. UNION MEMORIAL HOSPITAL

X

11-5-83

FUNERAL DIRECTOR: IMPORTANT

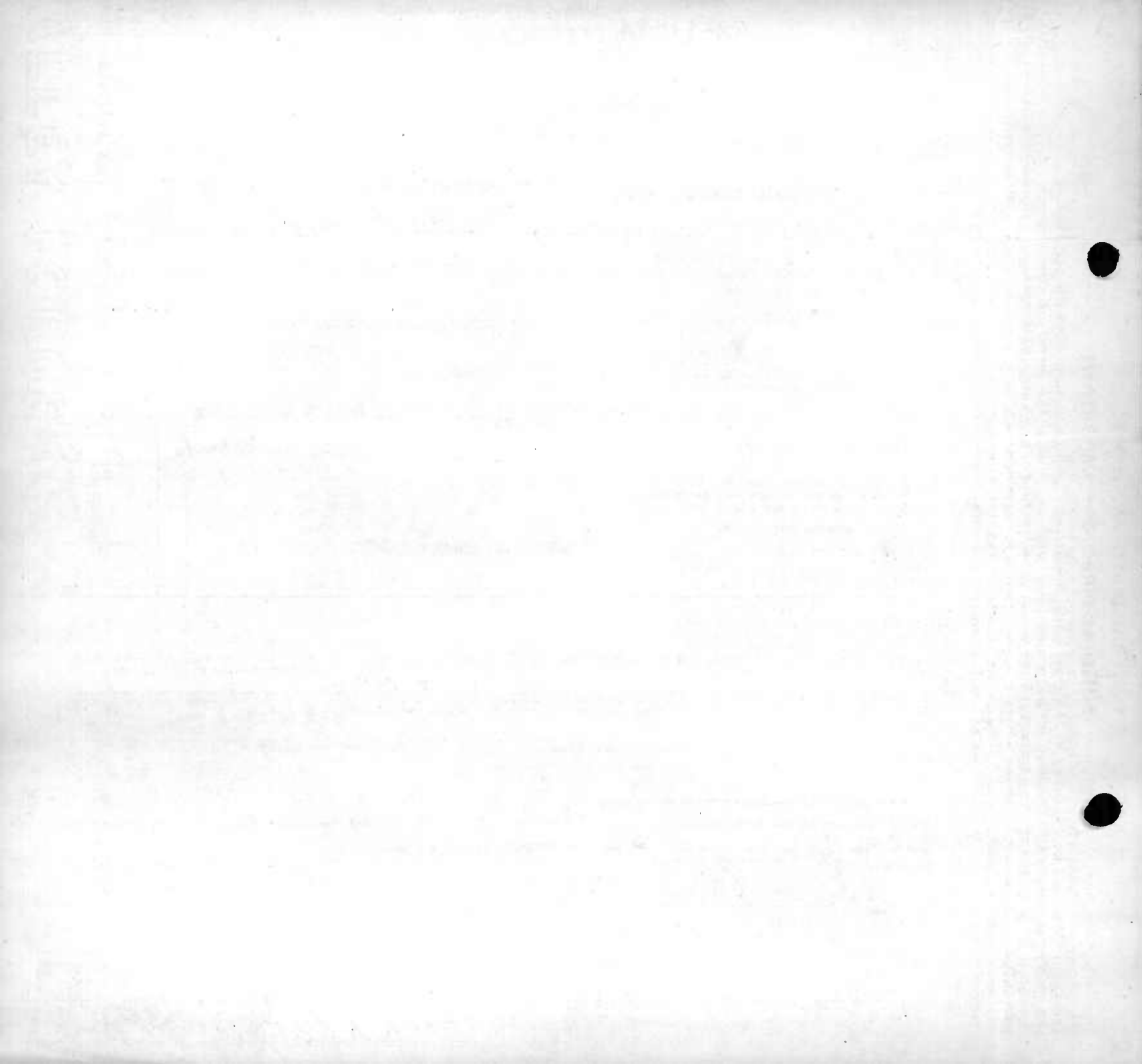
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11114

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11114

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Edward Patton		2. DATE AND HOUR OF DEATH November 2 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3310 Keswick Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3310 Keswick Rd.			
5. SEX male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1905	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Patton		14. MOTHER'S MAIDEN NAME Crowley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-12-7204		17. INFORMANT Joseph Patton 3310 Keswick Road.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I Coronary Arteriosclerosis Sudden		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 101d (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?		21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from November 1 1968 to November 2 1968 , that (H) (we) last saw the deceased alive on November 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) (they) (did not) view the body after death.					
23A. SIGNATURE Herman Brecher M.D.		23B. DATE SIGNED 11/4/68		23C. PHYSICIAN'S NAME (Type) HERMAN BRECHER, M.D.	
23D. ADDRESS 443 E. 25th St. Baltimore 18, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5-68	
24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION Baltimore, Md.		24E. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. J. [unclear]		25C. FUNERAL DIRECTOR Frank H. [unclear]	
25D. ADDRESS 814 W 36th St.					



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68-11112 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11112

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

HENRY TAYLOR

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐ October 31, 1968

6:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

October 31, 1968

6:00 P. M.

5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Montgomery Co 66-00

C. CITY OR TOWN

Marlow Heights

D. INSIDE CITY LIMITS?

YES ☐NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

2/4/1910

10. AGE (In years
last birthday)

58 58

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

5930 28th Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Will Taylor

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Millie Myers

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

Marion Taylor

ADDRESS

Same as 5 e & c

19. E812.10

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple Traumatic Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rte. #4 75 ft. south of Rte. 408

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

Oct. 26, 1968 6:02 p.m.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/4/68

24C. NAME of CEMETERY or CREMATORY

Geo. Washington Cem.

24D. LOCATION

(City, town, or county)

Hyattsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

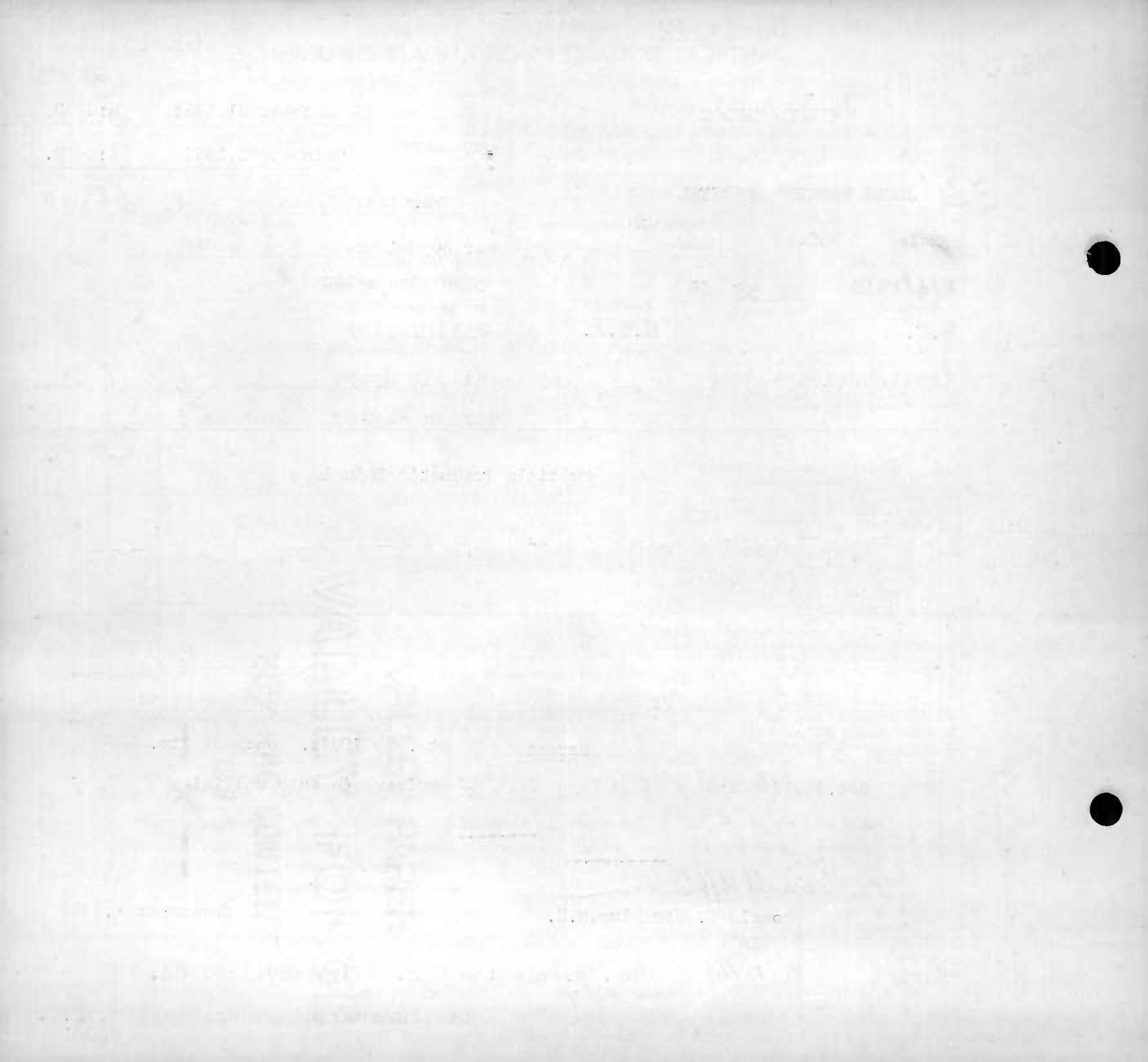
Robert E. Sankara

25C. FUNERAL DIRECTOR

Lee Funeral Home

ADDRESS

Washington, D.C.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11113 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11113

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Kathryn S. Ringler		2. DATE AND HOUR OF DEATH 10/29/68 1 7⁰⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Montgomery		
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 38			C. CITY OR TOWN Silver Springs D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 411 Greenbrier Drive		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/18/17	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Warren Shook		14. MOTHER'S MAIDEN NAME Kathryn Cellig	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. YES		17. INFORMANT Dorothy S. Buchly ADDRESS Silver Spring, Md. 9301 Compton Street	
18. 173.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of ovary			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis (B) DUE TO, OR AS A CONSEQUENCE OF: Cancer of ovary (C) _____		
19. 175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. 7 yrs.		
19A. DATE OF OPERATION 3 10/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/2/68 19 68 to 10/29 19 68 , that (I) (we) lost saw the deceased alive on 10/29/68 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dewitt E. Kemp M.D.				23B. DATE SIGNED 10/29/68	
23C. PHYSICIAN'S NAME (Type) Dewitt E. Kemp. M.D.				23D. ADDRESS UNIVERSITY HOSPITAL, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-1968		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Greencastle, Penna.					
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR Warner E. Humphrey, Inc. 8434 Ga. Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11115				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11115	
M.E. CASE NO. 68-22033				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HEARD, BABY BOY				2. DATE AND HOUR OF DEATH 11/3/68 11:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1029 Valley St.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Infant	8. DATE OF BIRTH 11/2/68	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? 24	
13. FATHER'S NAME James Heard				14. MOTHER'S MAIDEN NAME Julia Green			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 776.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) IDIOPATHIC RESPIRATORY DISTRESS SYNDROME				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 773.0 II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 11/2 19 68 to 11/3 19 68 , that (I) <u>(we)</u> last saw the deceased alive on 11/3 19 68 and that (I) <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above (I) <u>(we)</u> (did) (did not) view the body after death.							
23A. SIGNATURE Mary I. Olson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) Mary I. Olson, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/3/68		24C. NAME of CEMETERY or CREMATORY Johns Hopkins Hospital		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	

1/1/20

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1/1/20

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11116 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11116

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CECELIA WELLS

2. DATE AND HOUR OF DEATH

10/30/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

7111 Chambers Rd.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

7111 Chambers Rd.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

July 31, 89

9. AGE (In years
last birthday)

79

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Lindhorst

14. MOTHER'S MAIDEN NAME

Cecelia Dobrent

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

212-01-0200B

17. INFORMANT

James Wells

ADDRESS

Same

18. 4339 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CEREBRAL THROMBOSIS SUDDEN

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ARTEROSCLEROSIS 16 YRS

(C)

MEDICAL CERTIFICATION

332X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____,

that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Berger

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/2/68

24C. NAME of CEMETERY or CREMATORY

Parkwood Cem.

24D. LOCATION

(City, town, or county)

Balto. Co.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

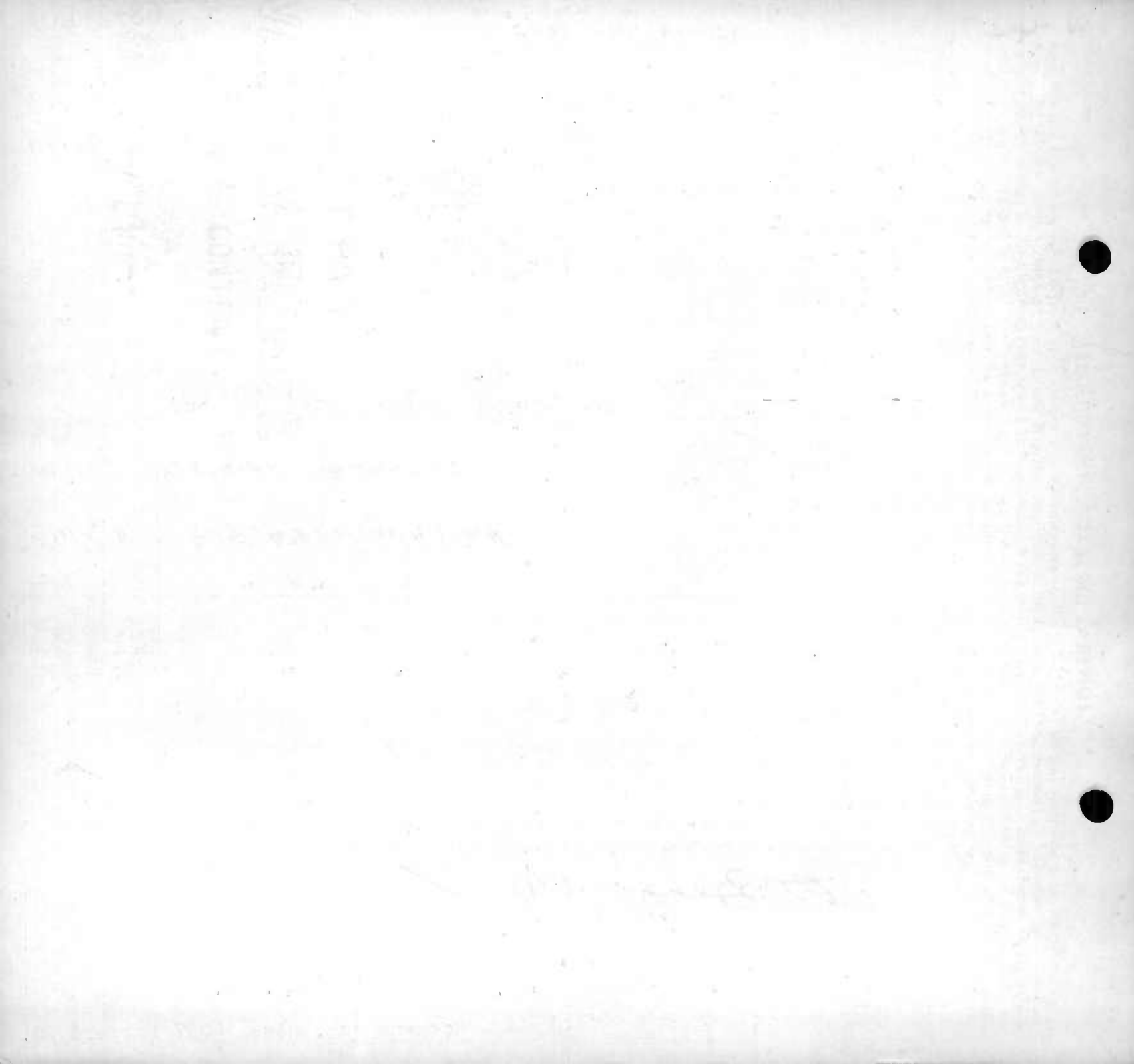
25B. NAME OF REGISTRAR

Reg. E. J. J. J.

25C. FUNERAL DIRECTOR

Heemann Fun. Home 6067 Harford Rd.

ADDRESS



Released by med. examiner in Frankfort
on approval 11-2-68 JEF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11117 CERTIFICATE OF DEATH

REG. NO. 68-11117

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FLORA E. SHAW		2. DATE AND HOUR OF DEATH 2 Nov 1968 7 25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE 18 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1332 Remington Avenue		5. SEX F 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH Nov 26 1875 9. AGE (In years last birthday) 92	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT James W. Shaw 6638 A Glen Bar Court		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PULMONARY EMBOLUS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2900.0 II		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: of x @ Hip (B) DUE TO, OR AS A CONSEQUENCE OF: — (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 24 hours	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 —		22. DATE OF OPERATION 0		23. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
24. AUTOPSY? (Yes or No) NO		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 53-00		26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	
27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		28. WHERE DID INJURY OCCUR? 1332 Remington Ave Balto 18		29. HOW DID INJURY OCCUR? Fell down steps	
30. TIME OF INJURY (APPROX.) 11/1/68 8AM		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		32. I certify that (1) (this hospital) attended the deceased from 1 Nov 1968 to 2 Nov 1968 , that (1) (we) last saw the deceased alive on 2 Nov 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.	
33. SIGNATURE [Signature] MD		34. DATE SIGNED 2 Nov 1968		35. PHYSICIAN'S NAME (Type) —	
36. ADDRESS		37. DATE		38. NAME OF CEMETERY or CREMATORY Mountland Memorial Park	
39. LOCATION (City, town, or county) (State) Taylor Ave		40. DATE REC'D BY HEALTH DEPT. NOV 6 1968		41. NAME OF REGISTRAR Paul E. Jenkins	
42. FUNERAL DIRECTOR Paul E. Jenkins		43. ADDRESS 365 Chestnut Ave		44. DATE REC'D BY HEALTH DEPT. NOV 6 1968	

2000 10 2

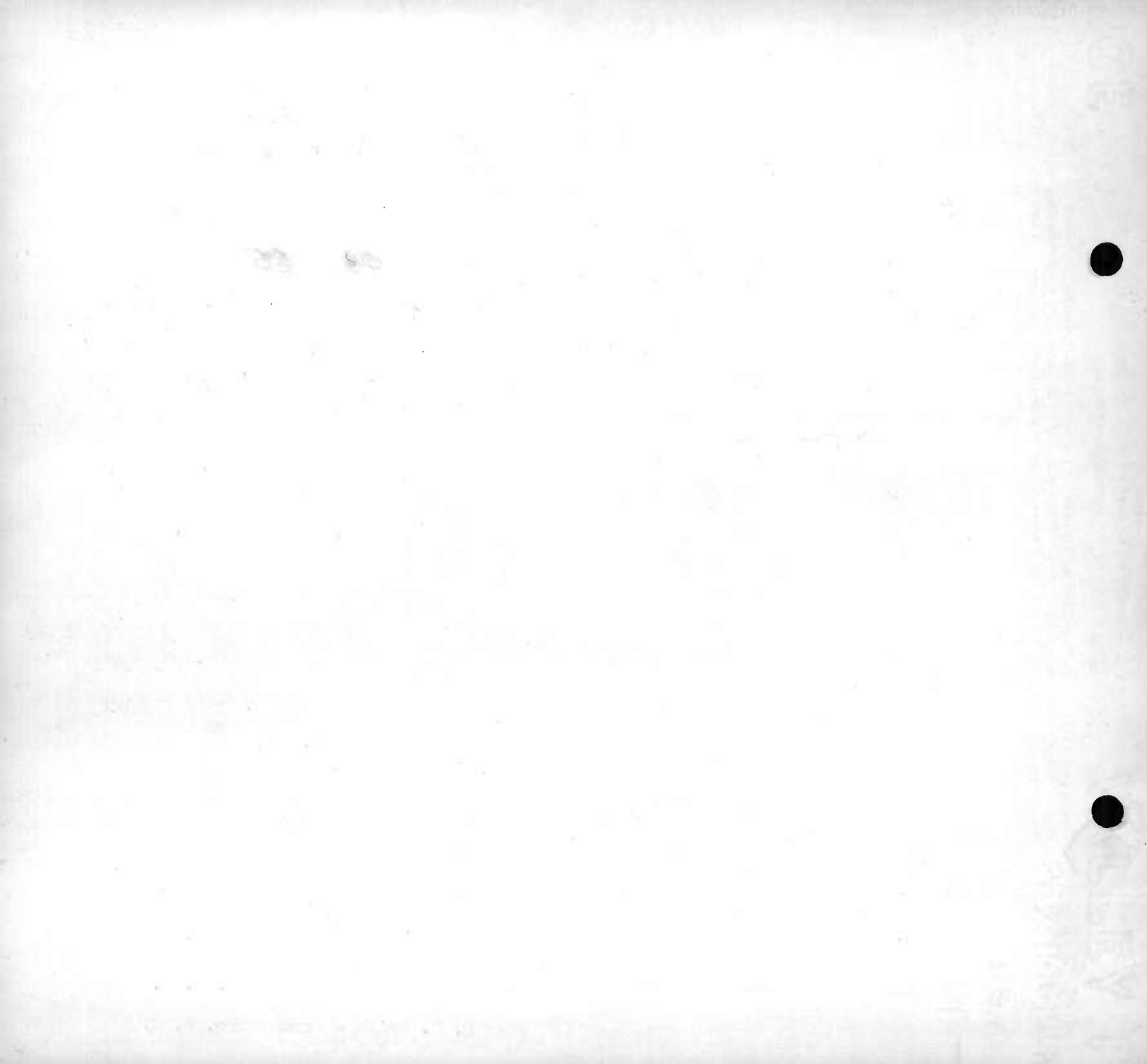
James M. Adams

James M. Adams

James M. Adams

Medical Examiner's Case - to be approved by Med. Examiner
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

10		68-11118		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11118	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert C. Sharpe				2. DATE AND HOUR OF DEATH Nov. 4, 1968 7:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-07			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Md. 46						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 507 Lyndhurst St.									
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/03		9. AGE (In years last birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greensboro, N.C.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Charles D. Sharpe				14. MOTHER'S MAIDEN NAME Mary Anne Holmes					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary S. Curtis (Sister) 117 Nelson St., Durham, N.C.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) Fracture of Right Tibia						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Fracture of Right Tibia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 4 weeks	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 507 Lyndhurst St. Baltimore, Md.					
21D. TIME OF INJURY (APPROX.) Oct. 6, 1968		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down basement steps					
22. I certify that (I) (this hospital) attended the deceased from Oct 6 19 68 to Nov 4 19 68, and that (I) (we) last saw the deceased alive on Nov 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William B. Russell, M.D.						23B. DATE SIGNED Nov. 4, 1968			
23C. PHYSICIAN'S NAME (Type) William B. Russell, M.D.						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-68		24C. NAME OF CEMETERY or CREMATORY Piedmont Memorial Park		24D. LOCATION (City, town, or county) (State) Greensboro, N. C.			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR E. E. Smith		25C. FUNERAL DIRECTOR E. E. Smith		25D. ADDRESS Greensboro, N. C.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED RANDALL

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

November 3, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 3, 1968

11:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Feb. 3, 1926

10. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3306 N. Hilton Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Phillip Vaughan

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Fannie Bradley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

217-20-5303

18. INFORMANT

Harry Randall - 3306 N. Hilton St.

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Laennec's cirrhosis
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-9-68

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 6 1968

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

MAILED FOR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11120

BIRTH NO.

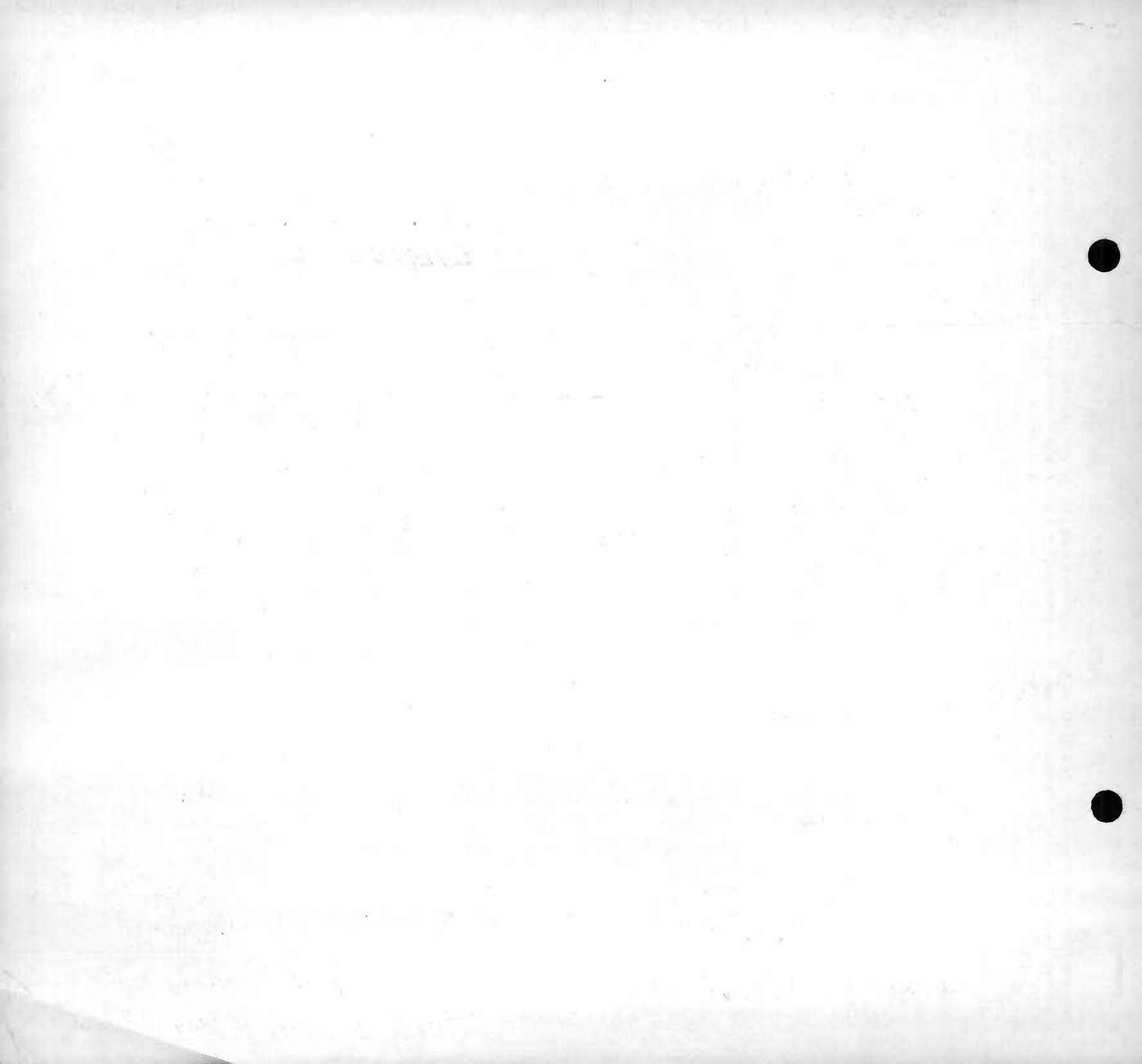
REG. NO.

1. NAME OF DECEASED (Type or Print) OSMOND W. DOWELL				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> October 31, 1968 Hour 7:10 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (DOA)				3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968 Hour 8:30 P.M.			
6. SEX male				7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-8-1908				10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Dowell			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Rose Webb				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT Jennie Pembroke - 3303 Winterbourne Road			
19. CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) DATE SIGNED 11/2/68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11-6-68			
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968				25B. NAME OF REGISTRAR Charles E. Sanborn			
25C. FUNERAL DIRECTOR Charles R. Law				ADDRESS 802 Madison Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11121	
1. NAME OF DECEASED (Type or Print)		WILLIAM BANKS		2. DATE AND/HOUR OF DEATH 11/3/68 2 ³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
31 4940 EASTERN AVENUE 21224 BALTIMORE CITY HOSPITALS		B. DATE OF BIRTH 6/10/03		E. STREET AND NUMBER 720 W. SPRINGS ST. 21205	
S. SEX MALE M		6. RACE NEGRO N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 65	
NONE		VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 219-01-1181A		17. INFORMANT BCH RECORDS		ADDRESS 4940 EASTERN AVENUE 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHIO-PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL CEREBRAL ART. THROMBOSIS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 332X II		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/24 to 11/3 1968, and that (I) (we) last saw the deceased alive on 11/3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Torres		23B. DATE SIGNED 11-3-68	
23C. PHYSICIAN'S NAME (Type) JOSE TORRES JOSE. TORRES		23D. ADDRESS 4940 EASTERN AVENUE 21224 BALTIMORE CITY HOSPITALS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/8/68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION A. A. County, Md		25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Joseph H. Lockridge	
25C. FUNERAL DIRECTOR Joseph H. Lockridge		25D. ADDRESS 1304 N. Central Ave			



68-11122

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11122

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOSEPH DRUMGOOLE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 3, 1968	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1968 3:36 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-15-22		10. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY Construction	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT ROSEMARY DRUMGOOLE		ADDRESS 1012 Stirling St	
19. CAUSE OF DEATH 371.8 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/7/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town or county) (State) G.A. County - Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Joseph E. Locke	
25C. FUNERAL DIRECTOR 1304 N. Central Ave		ADDRESS	

UNIT 8. MOUNTAIN VIEW

VA

UNIT 8. MOUNTAIN VIEW

UNIT 8. MOUNTAIN VIEW

UNIT 8. MOUNTAIN VIEW

UNIT 8. MOUNTAIN VIEW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
1. NAME OF DECEASED (Type or Print) <u>HOSEA WILLIAM</u>		2. DATE AND HOUR OF DEATH <u>11/4/68</u> :00 <u>P. M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MERCY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>5-02</u>		
5. SEX <u>♂</u> 6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/10/19</u> <u>49</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>REDDICK WILLIAM</u>		14. MOTHER'S MAIDEN NAME <u>DICIE BEMER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruberta Williams - 12358 Lawndale</u>
18. <u>493K I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIAC STANDSTILL</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>BRONCHIAL ASTHMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE + YEARS</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11/1/68</u> to <u>11/4/68</u> , that (I) (we) last saw the deceased alive on <u>11/4/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. Susan Bollinger</u>		23B. DATE SIGNED <u>11/5/68</u>		23C. PHYSICIAN'S NAME (Type) <u>M. SUSAN BOLLINGER</u>
23D. ADDRESS <u>MERCY HOSP</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>11/8/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 6 1968</u>		25B. NAME OF REGISTRAR <u>Charles R Rice</u>		25C. FUNERAL DIRECTOR <u>661 W. Bore St</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-09245				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11124	
1. NAME OF DECEASED (Type or Print) <i>Smith, R. Sherrie</i>				2. DATE AND HOUR OF DEATH <i>11-3-68 8:25 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>510 N. Calhoun St.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-20-68</i>		9. AGE (In years, last birthday) <i>4 yrs.</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Washington</i>				14. MOTHER'S MAIDEN NAME <i>Barbara Smith</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>		ADDRESS	
18. <i>746.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory arrest 2 hrs.</i> (B) <i>Myotic Aneurysm of Pulmonary artery.</i> (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>734.0 II</i>				<i>Tetralogy of Fallot.</i>			
19A. DATE OF OPERATION <i>11-1-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>MYCOTIC ANEURYSM</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <i>11</i> (this hospital) attended the deceased from <i>9. 21</i> 19 <i>68</i> to <i>11. 3</i> 19 <i>68</i> , that (I) <i>lost</i> last saw the deceased alive on <i>11. 3</i> 19 <i>68</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did not) view the body after death.							
23A. SIGNATURE <i>McFarley M.D.</i>				23B. DATE SIGNED <i>11. 3. 68</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> <i>RESIDENT</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-6-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Calhoun</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 6 1968</i>		25B. NAME OF REGISTRAR <i>Charles P. Rice</i>		25C. FUNERAL DIRECTOR ADDRESS <i>661 W. BARRE ST.</i>			

1890

History of the
Republic of the
Philippines

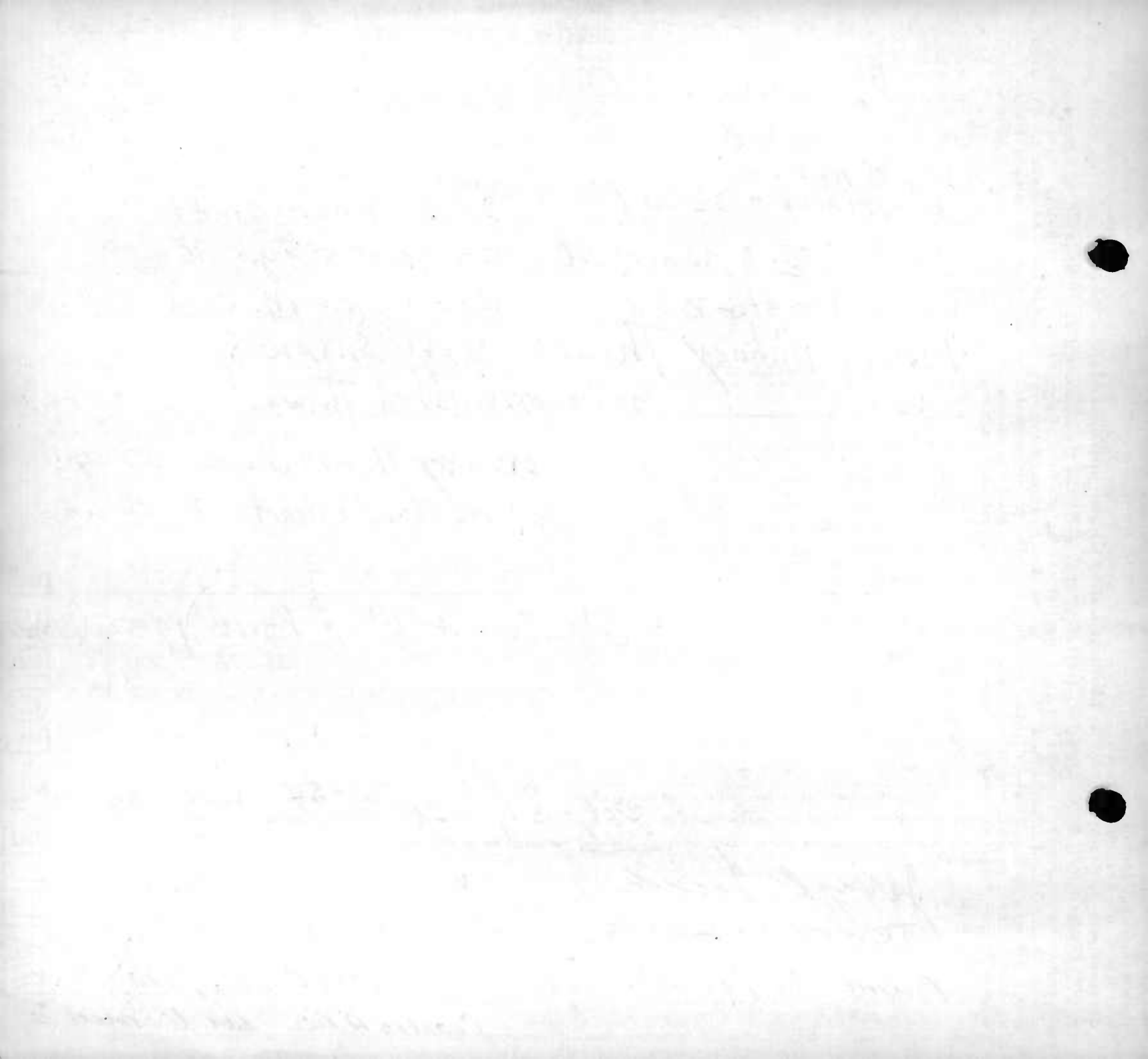
Vol. 1. 1890

1890

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

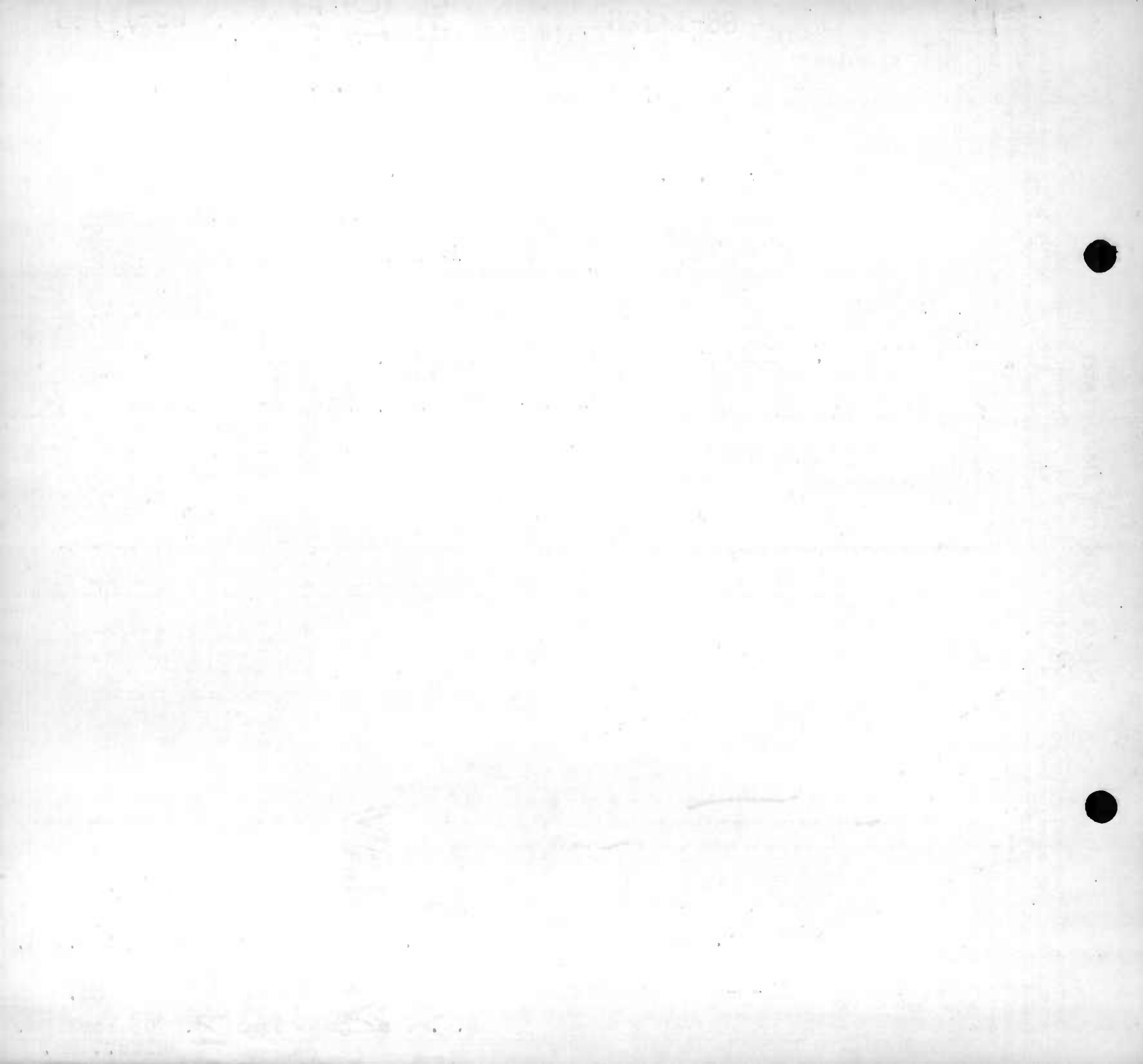
BALTIMORE CITY HEALTH DEPARTMENT									
68-11125					CERTIFICATE OF DEATH		Registered No. 68-11125		
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>William Clyde Thomas</i>					2. DATE AND HOUR OF DEATH <i>Nov. 3, 1968 9:00 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>25-33</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2408 Annow Ct. Baltimore 30 md</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
D. STREET ADDRESS (If rural, give location) <i>2408 Annow Court</i>									
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>12-13-1908</i>	9. AGE (In years last birthday) <i>59 yrs</i>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>machine operator none</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Winston Salem, N.C., U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albert Pinkney Thomas</i>			14. MOTHER'S MAIDEN NAME <i>Mary Susan Spease</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>243-10-6074</i>		17. INFORMANT ADDRESS <i>Mildred Thomas; same (wife)</i>				
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <i>CORONARY Heart Disease 3 days</i> DUE TO (B) <i>Arterio Sclerotic Heart Disease 14 yrs.</i> DUE TO (C)				
18. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Glaucoma A (Blind Results) 1954 (14 yrs)</i>									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1954 to Nov. 3, 1968</i> that (I) (we) last saw the deceased alive on <i>Oct. 31, 1968</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Jerry C. Luck</i> M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>Nov. 3, 1968</i>				
23C. PHYSICIAN'S NAME (Type) <i>Jerry C. Luck</i> M.D.					23D. ADDRESS <i>427 Swale Rd, Baltimore, md</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>11/7/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 6 1968</i>			25B. NAME OF REGISTRAR <i>Charles A. Rice</i>			25C. FUNERAL DIRECTOR ADDRESS <i>661 W. BARRE ST.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11126
68-11126		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		SARAH C. MEDINGER		Nov. 4, 1968 9:25 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green N. H.		A. STATE B. COUNTY Maryland Baltimore 53-00		
		C. CITY OR TOWN D. INSIDE CITY LIMITS? Balto. 21212 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER 233 Rodgers Forge Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
F	W		4-12-1881	87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		Own Home		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
William F. Collison		Sarah C. Ashcom		MSA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		215-48-0594		Helen M. Mulvenny Above
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u>		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <u>Hypertension</u>		
450.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? yrs.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 1/23 1938 to 11/4/68 that (I) (we) last saw the deceased alive on 9/28/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.				
23A. SIGNATURE <u>Francis W. Gluck</u>				23B. DATE SIGNED 11/4/68
23C. PHYSICIAN'S NAME (Type) Francis W. Gluck MD				23D. ADDRESS 100 W. University Parkway, Balto., Md.
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	11-6-68	Greenmount	Baltimore	Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 11-650 68-11127		BALTIMORE CITY HEALTH DEPARTMENT		68-11127	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Eva Moran		11/3/68 9:10 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland	
33 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3204 E Balto. Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	Widowed	7/24/92	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
	Housewife	Poland	U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		ADDRESS	
Walter Olszewski		Anna Koprowski		Mrs. Bertha Brown 3011 Kentucky Avenue	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		212 05 9157		Mrs. Bertha Brown 3011 Kentucky Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		36 hours	
ANTECEDENT CAUSES		(B) DUE TO		48 Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Ascites, cirrhosis, UGI bleed		5 days	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/1/68		Tracheostomy for pneumonia		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/29/68 19 to 11/3/68 19, that (I) (we) last saw the deceased alive on 11/3/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kevin Hennessy				11/3/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Kevin Hennessy		Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-6-1968		Holy Rosary	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore County, Maryland		NOV 6 1968		Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

James H. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-500		68-11128		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11128	
1. NAME OF DECEASED (Type or Print) Mann, Helen L.				2. DATE AND HOUR OF DEATH 11/5/68 9²⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital				C. CITY OR TOWN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12/5/03		9. AGE (In years last birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Norfolk	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME Unity Dossell				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 2/7-09-0608			
16. SOCIAL SECURITY NO. 216059991				17. INFORMANT John W. Mann		ADDRESS SAA	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Worsening Myocardial Infarction				(B) DUE TO, OR AS A CONSEQUENCE OF ISCVD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 42011 II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/3/68 to 11/5/68 , that (I) (we) lost saw the deceased alive on 11/5/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. M. De los Santos Jr. M.D.						23B. DATE SIGNED 11/5/68	
23C. PHYSICIAN'S NAME (Type) E. M. DE LOS SANTOS JR.						23D. ADDRESS U G H	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/8/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Taylor Ave Balt Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR E. J. Feltz		25C. FUNERAL DIRECTOR Leeds		ADDRESS Box 7200 Harford Road	

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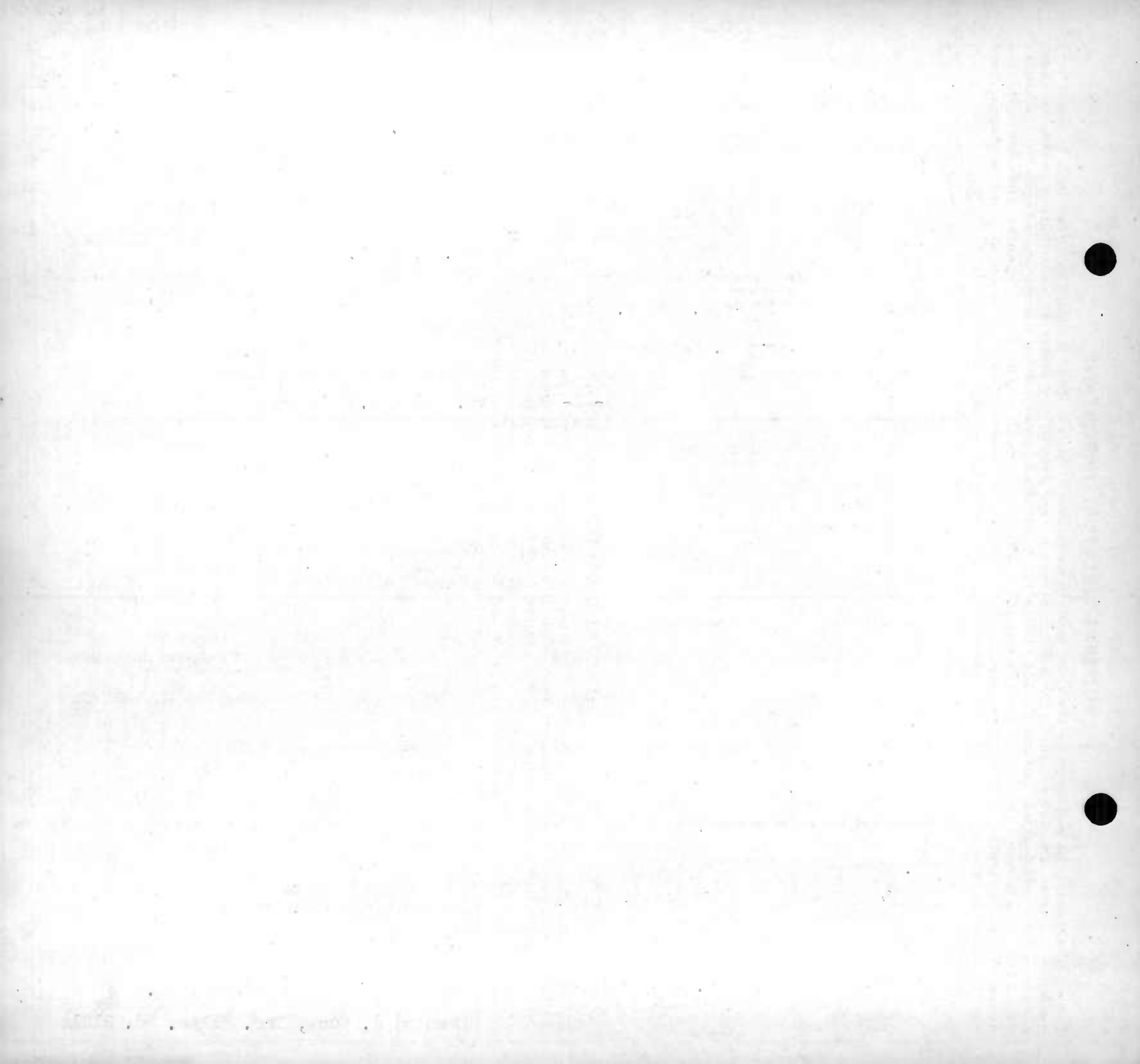
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11129 CERTIFICATE OF DEATH				REG. NO. 68-11129	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES H. KOHLHEPP		2. DATE AND HOUR OF DEATH 5 NOV 68 1 38 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital.			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2204 Gibbons Avenue		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1913.	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transit & Traffic Dept. Balto. City			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry S. Kohlhepp			14. MOTHER'S MAIDEN NAME Lorretta Dunn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-12-0324		17. INFORMANT Mrs. Julia A. LeFevre
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Thrombosis @ middle cerebral artery			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension chronic Bronchitis					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 5-02-1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 30 OCT 19 68 to 5 NOV 19 68 , that (H) (we) last saw the deceased alive on 5 NOV 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Salvatore R. Donohue M.D.				23B. DATE SIGNED 5 NOV 68	
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11130

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68-11130

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PHILIP WEBER

2. DATE AND HOUR OF DEATH

5th November 1968 06.30am M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*Church Home & Hospital
Baltimore Maryland 21231.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *MD.* B. COUNTY *Harford*

C. CITY OR TOWN

Baltimore 21214

D. INSIDE CITY LIMITS?

YES ☒ NO ☒

E. STREET AND NUMBER

2039 Randlewood Road

5. SEX

N

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-28-97

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland USA

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unk. Julian

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

215-05-6931

17. INFORMANT

Mr. Thomas E. Weber

ADDRESS

(Same)

18. *412.31*

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE *ARTHRIO-SCLEROTIC HEART* 5 years
DUE TO, OR AS A CONSEQUENCE OF: *Disease*

(B) *ABDOMINAL ANEURYSM* 1 week
DUE TO, OR AS A CONSEQUENCE OF:

(C) *EMBOLE ARTERY OCLUSION* 10 week

420.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

11-2-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

occlusion of femoral artery none

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *10-30-68* 19 to *11-5-68* 19, that (I) (we) lost saw the deceased alive on *10-4-68* 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

P. Van Coney and

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

11-5-1968

23C. PHYSICIAN'S NAME (Type)

PHARM VAN CONEY and

23D. ADDRESS

*Church Home Hosp
100 N. Broadway St.*

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/68.

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc. Balto. Md. 21214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11131

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		CLARENCE A. KELLY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
						November 3, 1968		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
University Hospital (DOA)						November 3, 1968		12:10 P.M.	
6. SEX				7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Male		Negro				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
9-30-1918		50		Philadelphia, Pa.		U.S.A.		THOMAS E. KELLY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Unemployed						MARY LOTTIE KELLY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
				219-01-5565		Mrs. Mary Kelly 3708 Flowerton Road			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)	
2								Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				Charles S. Springate, M.D.				DATE SIGNED	
EXAMINER'S NAME (Type)				November 4, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11-7-68		Baltimore Nat'l Cem.		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 6 1968		Morton & Dyett F.H.		MORTON & DYETT F.H.		1701 Laurens St.			

1964

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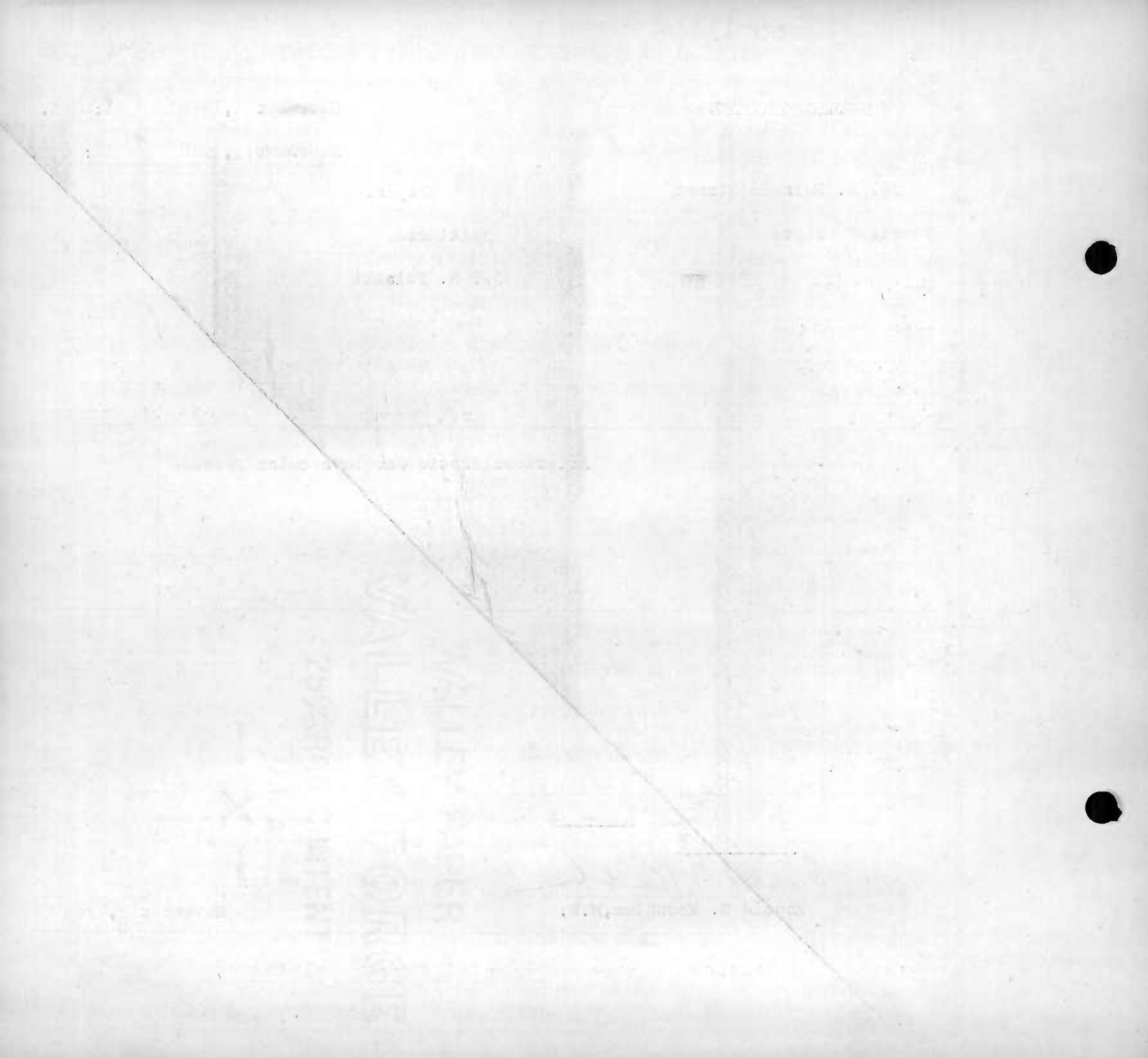
1964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11132

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NELLIE McDANIEL (NETTIE)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 1, 1968 Hour 11:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 507 N. Pulaski Street		3. DATE PRONOUNCED DEAD Month Day Year Hour November 1, 1968 11:00 A.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March, 1910	10. AGE (In years last birthday) 58	11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME TOM BROWN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME BETTY WELLINGTON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Brown 507 N. Pulaski Street	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED November 1, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR Regis E. Jackson	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John W. Buckley		November 5 1968		5 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
90 Hillcrest Nursing Home 212 Stoney Run Lane		Md Baltimore		C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5 Oct 1893		9. AGE (In years lost birthday) 75		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tin Smith		Smelting		Md	
13. FATHER'S NAME John J. Buckley		14. MOTHER'S MAIDEN NAME Mary -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes USN 12 Jun 1910 - 4 Oct 13		212-10-1315		John J. Buckley	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Generalized Atherosclerosis Basilar Artery Stroke				1 yr	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
334 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		URINARY Tract infection		3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 29 1968 to November 5 1968, that (I) (we) lost saw the deceased alive on Nov 1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Goldgeier				23B. DATE SIGNED Nov 6, 1968	
23C. PHYSICIAN'S NAME (Type) SHERDON GOLDGEIER				23D. ADDRESS 848 W 36 St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7 Nov 68		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
Nov 6 1968		John J. Buckley		Burger Funeral Home Balto Md	

1
5-143

68-11134 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11134

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) W. Paul Shiflett, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 11 2 1968 Hour 11:26 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 1968 11:40 PM	
6. SEX M		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 53-00	
9. DATE OF BIRTH 4/25/44		10. AGE (In years lost birthday) 24	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY General Motors	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-40-2096	
13. FATHER'S NAME Paul W. Shiflett, Sr.		15. MOTHER'S MAIDEN NAME Betty Elbon	
18. INFORMANT Paul W. Shiflett, Sr.		ADDRESS RD#1 New Park, Penna. 17352	

19. CAUSE OF DEATH E816.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Craniocerebral injuries. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E823.4			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 53-00 Rolling Mill Rd., 2000 ft. North of Balti-	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11, 2, 1968 11:26 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? more Street driver of auto which lost control.	

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Werner U. Spitz* M.D.
EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **11/3/1968**
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/68		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 6 1968		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR Robert C. Altenburg		ADDRESS 6009 Harford Rd.-Balto., Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3) X-6113

68-11135

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11135

BIRTH NO.		1. NAME OF DECEASED (Type or Print) KRAFT, MINNIE D		2. DATE AND HOUR OF DEATH 11-5-68 2:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5743 EDMONDSON AVE.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-28	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Link		14. MOTHER'S MAIDEN NAME MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Samuel Koehler	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ATRIAL FIBRILLATION AND DECOMPENSATION (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 DAYS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-11-1968 to 11-5-1968 , that (I) (we) last saw the deceased alive on 11-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge Garcia M.D.				23B. DATE SIGNED 11-5-68	
23C. PHYSICIAN'S NAME (Type) JORGE GARCIA M.D.				23D. ADDRESS LUTHERAN HOSPITAL OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68		24C. NAME OF CEMETERY or CREMATORY Trinity	
24D. LOCATION BALTO		24E. (City, town, or county)		24F. (State) MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR Theresa L. Sullivan	
25D. ADDRESS		25E. ADDRESS 4101 Edmondson Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11136

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11136

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LINCOLN, BOOKER T. WASHINGTON

2. DATE AND HOUR OF DEATH

10-29-68

9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1122 E. 20TH ST.

5. SEX

MALE

6. RACE

NON WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-1-13

9. AGE (In years
last birthday)

55

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Simon Lincoln

14. MOTHER'S MAIDEN NAME

ANN Margaret Dickie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

247-20-2372

17. INFORMANT

DR. C. N. RAO, FRANKLIN SQUARE HOSPITAL
100 N. CALHOUN STREET, BALTIMORE,

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Ischemia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest
ACUTE MYOCARDIAL INFARCTION

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-26 1968 to 10-29 1968,
that (I) ~~was~~ last saw the deceased alive on 10-29-1968 and that in (my) ~~own~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~was~~ (did) ~~not~~ view the body after death.

23A. SIGNATURE

C. NAGESWARA RAO,
M.D., DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

10-29-68

23C. PHYSICIAN'S
NAME (Type)

DR. C. NAGESWARA RAO

23D. ADDRESS

FRANKLIN SQUARE HOSPITAL
100 N. CALHOUN STREET, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial 11-2-68

24B. DATE

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial

24D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

R. P. S. J. J. J.

25C. FUNERAL DIRECTOR

Arbutus Memorial

25D. ADDRESS

1727 N. Mount

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11137

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RALPH LEE WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 1, 1968 Hour 10:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968 Hour 10:40 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 7-9-1949		10. AGE (In years last birthday) 19	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME William Wilson		14. MOTHER'S MAIDEN NAME Rachel Hodge	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot Wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 3591 Park Heights Ave. 22D. TIME OF INJURY (APPROX.) 11/168 9:30 P. M. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Subj. shot by policeman	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11/2/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-68	
24C. NAME OF CEMETERY or CREMATORY Carter Mem. Ph. Laurel		24D. LOCATION (City, town, or county) (State) md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Mount St.	

P-1-P-1

W. J. P. 1-1

W. J. P. 1-1
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W. J. P. 1-1

W. J. P. 1-1

W. J. P. 1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11138 CERTIFICATE OF DEATH

REG. NO.

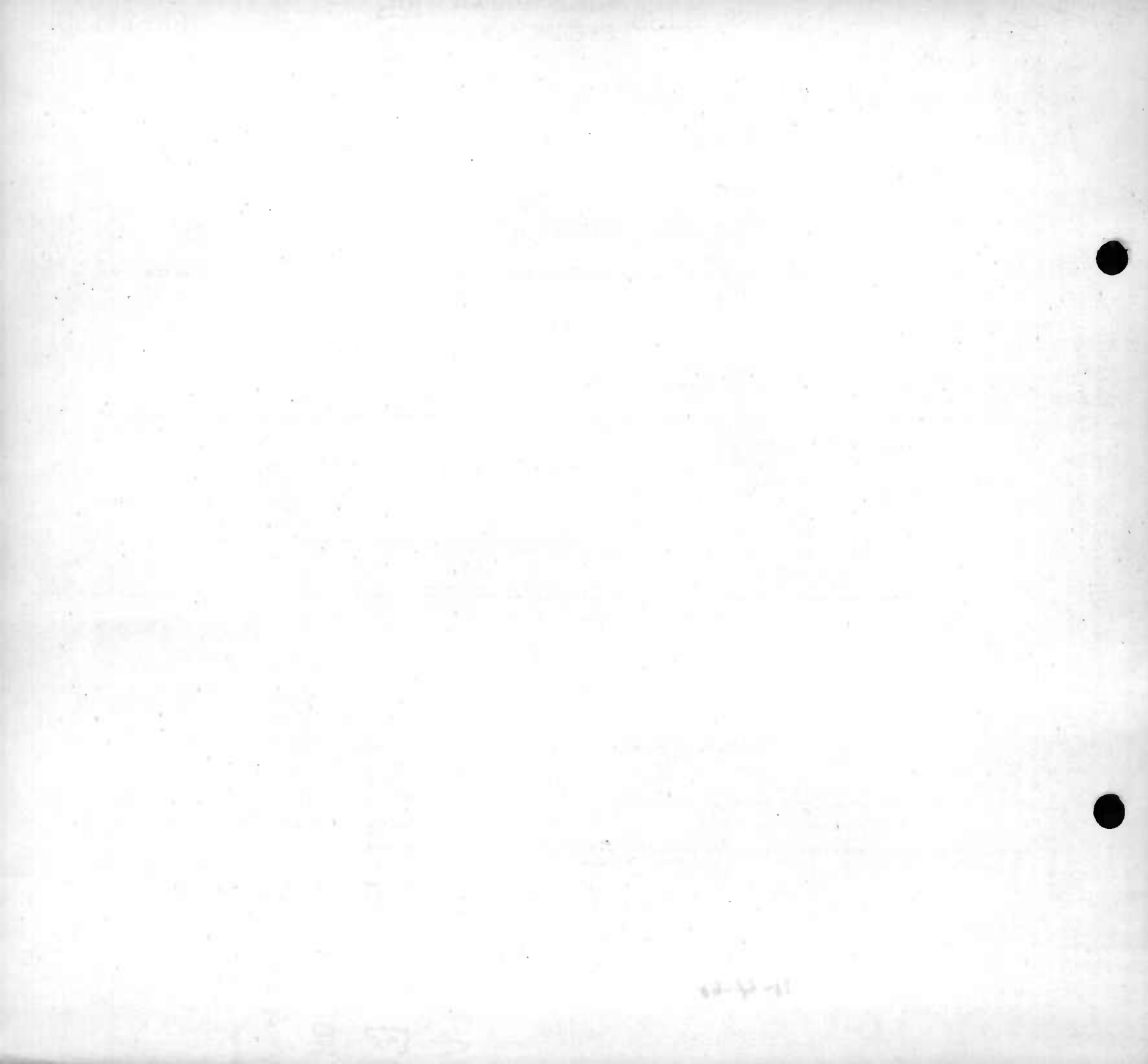
68-11138

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCIS C LABAK		2. DATE AND HOUR OF DEATH OCT. 25 1968 8:06 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSP.			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 109 PRATT ST.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 55	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME P		
14. MOTHER'S MAIDEN NAME P			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT 109 PRATT ST. ADDRESS		
18. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF:		
(C)					
MEDICAL CERTIFICATION					
18. 381.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT 15 1968 to OCT 25 1968 , that (I) we last saw the deceased alive on OCT 25 1968 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Deegan MD				23B. DATE SIGNED 10/25/68	
23C. PHYSICIAN'S NAME (Type) M. J. DEEGAN JR.				23D. ADDRESS UNIVERSITY MEDICAL SCHOOL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-4-68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) STATE		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR 11-4-68	
25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11139 4
BIRTH NO. <u>68-19855</u>			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Baby Boy McDaniels</u>			2. DATE AND HOUR OF DEATH <u>14 Oct 1968</u> <u>15:30 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Univ. of Md. Hosp</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>male</u>			6. RACE <u>Negro</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>15 Oct 68</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Shirley McDaniels</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Jane C. McCaffrey M.D. Univ. of Md. Hosp.</u>			ADDRESS		
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>776X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY <u>Yes</u> or <u>No</u> <u>NO</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>14 Oct 1968</u> to <u>14 Oct 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>14 Oct 1968</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Jane C. McCaffrey M.D.</u>			23B. DATE SIGNED <u>14 Oct 68</u>		
23C. PHYSICIAN'S NAME (Type) <u>JANE C. MCCAFFREY</u>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>11-4-68</u>			24B. DATE		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 7 1968</u>			25B. NAME OF REGISTRAR <u>Phyllis E. Jackson</u>		
25C. FUNERAL DIRECTOR			25D. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11140		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11140	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bennie Banks		November 5, 1968 7:10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc.			A. STATE Maryland B. COUNTY 15-01		
			C. CITY OR TOWN Baltimore,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1528 Baker Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-09	9. AGE (In years last b-day) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. Robinson			14. MOTHER'S MAIDEN NAME Nae		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219381133	17. INFORMANT ADDRESS Mrs. Ruth Banks-Daughter-in-law SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) Hypertensive Cardiovascular disease (C) _____		
19. DATE OF OPERATION 443X II			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from October 31, 1968 to November 5, 1968, that (I) (we) last saw the deceased alive on November 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Greg Tenger MD			23B. DATE SIGNED 11-5-68		
23C. PHYSICIAN'S NAME (Type) GREG TENGCO MD			23D. ADDRESS 1514 Division Street Balto., Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-8-68	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Bailey	25C. FUNERAL DIRECTOR V.R. Bailey Kelson F. H. 1348 N. Calhoun St.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on APPROVAL by the ME Office per [Signature]

68-11141

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11141

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Davis, Bertha

2. DATE AND HOUR OF DEATH

Nov. 1, 1968 12²⁹ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

83 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
1810 Aiken St. Maryland

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1810 Aiken St.

5. SEX

F

6. RACE

N

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-8-21

9. AGE (In years last birthday)

47

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM MORTON

14. MOTHER'S MAIDEN NAME

MARGARITA JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

24-14-0388

17. INFORMANT

BERTILLA DAVIS 1810 AIKEN ST

ADDRESS

18.

519.021

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Perforation of Bronchus & Pulmonary Hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Incident to Bronchoscopy

(B) Antecedent Cause

DUE TO, OR AS A CONSEQUENCE OF:

Chronic Bronchitis

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3-1-1-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

dx of lung lesion

20A. AUTOPT? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

11-1-68

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Hospital O.R.

21C. WHERE DID INJURY OCCUR?

Johns Hopkins Hospital

(If in Baltimore City, give exact location)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☒

21F. HOW DID INJURY OCCUR?

Therapeutic Misadventure

22. I certify that (I) (this hospital) attended the deceased from 11-1-68 to 11-1-68, that (I) (we) last saw the deceased alive on 11-1-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald G Michels MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-1-68

23C. PHYSICIAN'S NAME (Type)

Ronald G Michels MD

23D. ADDRESS

Johns Hopkins Hosp

24A. BURIAL CREMATION REMOVAL (Specify)

BURIAL

24B. DATE

11-6-68

24C. NAME of CEMETERY or CREMATORY

MT CALVARY

24D. LOCATION (City, town, or county)

CEARHILL OR. Co.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 2 1968

25B. NAME OF REGISTRAR

John E. Johnson

25C. FUNERAL DIRECTOR

JOSEPH HARTIG 1639 N. BROADWAY

ADDRESS

YES

FUNERAL DIRECTOR: IMPORTANT

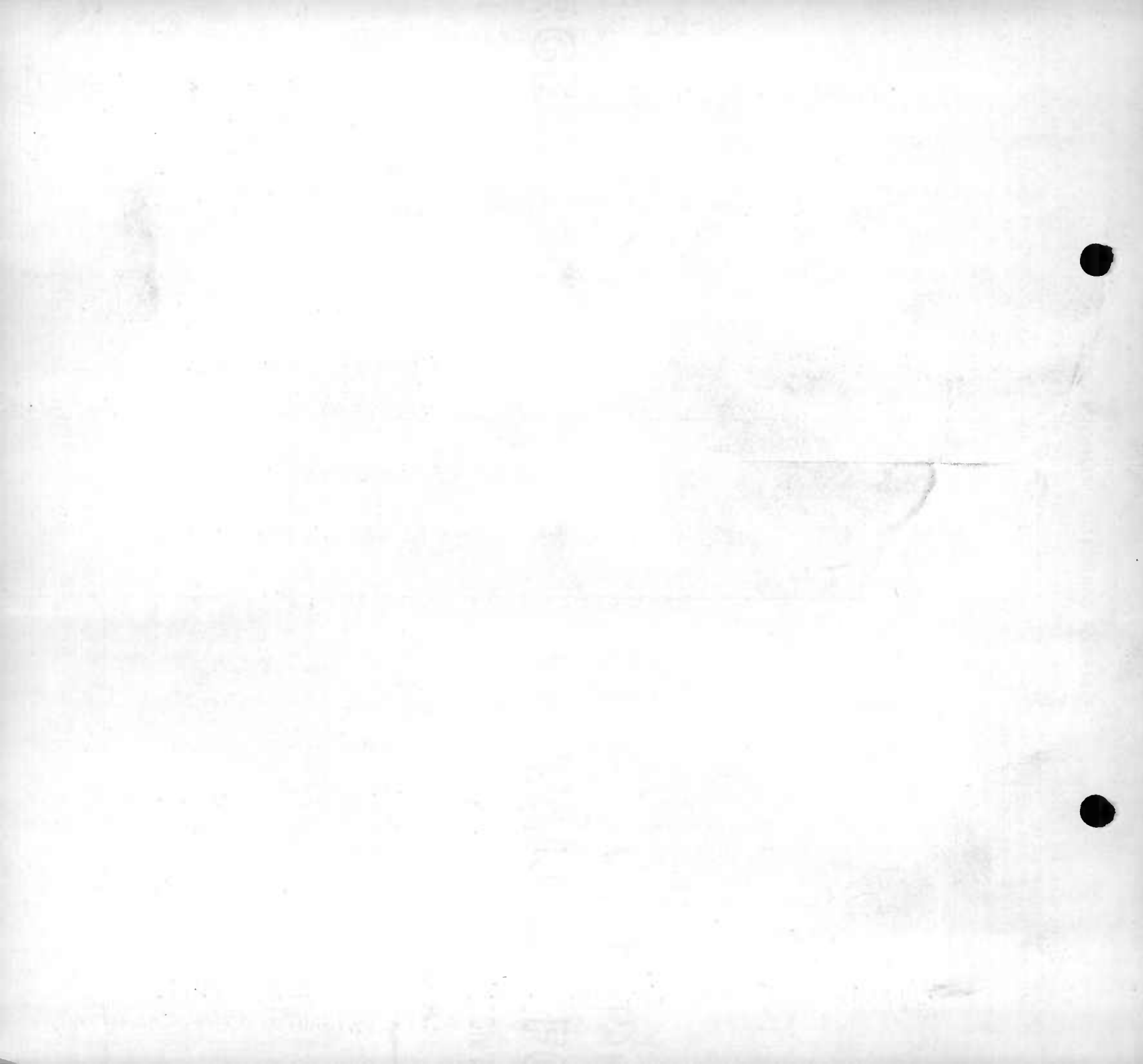
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11142

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11142

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ernest Fenderson		2. DATE AND HOUR OF DEATH 11-3-68 1:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Swine Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore md B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Swine Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore md D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4005 Ayndale Ave					
5. SEX M	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 10-17-23	9. AGE (In years last birthday) 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ERNEST FENDERSON		14. MOTHER'S MAIDEN NAME ESTHER HARDESTY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.2		16. SOCIAL SECURITY NO. 217-12-8071		17. INFORMANT ELAINE FENDERSON	
18. 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma (B) The basal C Metastasis DUE TO, OR AS A CONSEQUENCE OF: (C) 153.8 II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes!	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-3-68 19 to 11-3-68 19, that (I) (we) last saw the deceased alive on 11-3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sam LeBauer md				23B. DATE SIGNED 11-3-68	
23C. PHYSICIAN'S NAME (Type) Sam LeBauer md		23D. ADDRESS Swine Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-8-68		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION (City, town, or county) BALTO md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Stahura		25C. FUNERAL DIRECTOR JOSEPH KNIGHT	
				ADDRESS 1639 N. BROADWAY	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11143	
BIRTH NO. 68-11143		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Isabella Sain		2. DATE AND HOUR OF DEATH November 3 1968	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 573 W Presstman St		A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-03	
		D. STREET ADDRESS (If rural, give location) 575 W. Presstman St			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH May 6, 1907	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore md	
13. FATHER'S NAME Thomas Kiley		14. MOTHER'S MAIDEN NAME Clara Wallace		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Bessie Johnson 1605 E. North Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic kidney condition		CAUSE OF DEATH (A) DUE TO Diabetes (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 8 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 422.2 II					
19A. DATE OF OPERATION 11/1/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/24/68 to 11/31/68 , that (I) was last saw the deceased alive on 11/1/68 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Cmt	
24D. LOCATION (City, town, or county) (State) Arbutus md		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS 1000 Broadway Rd			

Hand

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11144

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11144

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Odell Lucille Epps

2. DATE AND HOUR OF DEATH

8:10 Nov 1/68 5:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

381 University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland -

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1041 Lanvale St.

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11/1/07

9. AGE (In years
last birthday)

61

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

domestic

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Morehead

14. MOTHER'S MAIDEN NAME

Addie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-05-8716

17. INFORMANT

Charles Samorodin M.D.

ADDRESS

Univ Hosp

18.

412.41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

assumed from my signs

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Renal failure

(C)

C.H.F. - 2° to ASCVD

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐

Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 25 19 68 to Nov 1 19 68,
that (I) (we) last saw the deceased alive on 3:10 AM Nov 1 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles Samorodin M.D.

Attending ☐

Med. ☐

Staff ☒

23B. DATE SIGNED

11/1/68

23C. PHYSICIAN'S
NAME (Type)

Charles S. Samorodin M.D.

23D. ADDRESS

University Hospital

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

11-5-68

Mt Auburn Cem

Balto

MD 21230

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Nov 6 1968

Robert E. Johnson

Elroy O. Wilson

100

Chap. 10. 100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11145

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPHINE CHAPPELL

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 3, 1968

10:05 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

April 30, 1924

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

131 Aisquith St., Apt #7.G

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Gibson

15. MOTHER'S MAIDEN NAME

Dorothy Banks

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Dorothy Banks

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Jutube Beavers

ADDRESS

19.

E966X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stabwound of chest
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

E982X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

131 Aisquith St., Apt #7.G

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

?

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed by unknown assailant

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-7-68

24C. NAME of CEMETERY or CREMATORY

Baltimore City

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

Baltimore

25C. FUNERAL DIRECTOR

Baltimore

ADDRESS

Baltimore

RECEIVED

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

NOV 19 1964

VALLEY FORD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11146

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NATHANIEL JONES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 4, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (HOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 4, 1968 12:24 AM	
6. SEX Male	7. RACE Negro	5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
8. DATE OF BIRTH July 31-1918		9. AGE (In years lost birthday) 50	
10. BIRTHPLACE (State or foreign country) Baltimore Md		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME John B Jones	
14. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Blue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 217-01-9759	
18. INFORMANT Maude Jones		ADDRESS Home	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
21. DATE OF OPERATION		22. AUTOPSY? (Yes or No) Yes	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED			
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED November 4, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-68	
24C. NAME OF CEMETERY or CREMATORY Mount Airy Cal		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Walter E. Taylor	
25C. FUNERAL DIRECTOR Gray Wilson & Son		ADDRESS Baltimore	

WALLEY, JOHN

WALLEY, JOHN

WALLEY, JOHN

WALLEY, JOHN

WALLEY, JOHN

WALLEY, JOHN

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WALLEY, JOHN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-11147

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

QUOMONY James Edward

2. DATE AND HOUR OF DEATH

11-1-68

10:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 212184. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

2520 East Eager Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-20-32

9. AGE (In years
lost birthday)

36

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Havre DeGrace, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Quomony

14. MOTHER'S MAIDEN NAME

Martha Morgan

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

12-29-49 to 11-29-61

16. SOCIAL
SECURITY NO.

214-26-68-11

17. INFORMANT VA Hospital Records

ADDRESS

Baltimore, Maryland 21218

18. 156.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Respiratory arrest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ulcerative colitis
carcinoma of common bile duct, hepatic ducts,
and multiple hepatic abscesses

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C).....

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 Hr.

3 Months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 24, 19 68 to November 1, 19 68,
that (I) (we) last saw the deceased alive on November 1, 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.

23A. SIGNATURE

Ellis L. Jones

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-2-68

23C. PHYSICIAN'S
NAME (Type)

Ellis L. Jones

M. D.

DEGREE

23D. ADDRESS V. A. Hospital

3900 Loch Raven Blvd., Baltimore, Md. 21218

24A. BURIAL CREATION,
REMOVAL (Specify)

Burial

24B. DATE

11-6-68

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cat

24D. LOCATION

Balto

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

NOV 1 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Clay Anderson

ADDRESS

Brimley St

11

11

11

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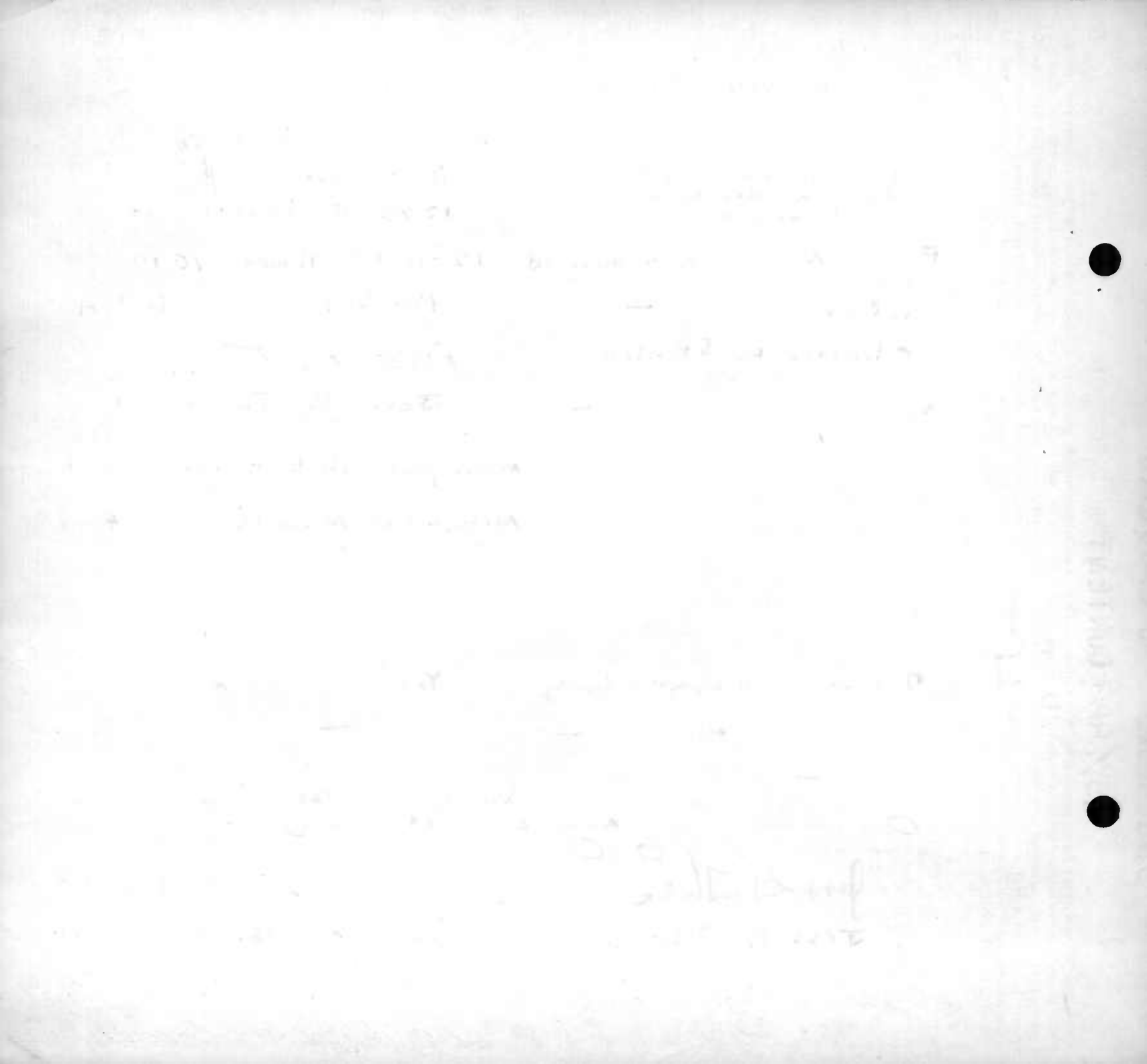
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11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-11148		68-11148		68-11148	
M.E. CASE NO. 67-25152					
1. NAME OF DECEASED (Type or Print) Crystal Stinson			2. DATE AND HOUR OF DEATH 11 AM 11-2-68		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital 601 N. Broadway Baltimore, Md.			A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1340 E. Fayette St.		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 12-16-67	9. AGE (In years lost birthday) 11 mos.	If Under 1 Yr. Months Days Hours Min. 10 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Chester L. Stinson.			14. MOTHER'S MAIDEN NAME Prige Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Jess G. Thoene, M.D.		ADDRESS
18. 1922/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Meningeal Metastases (B) DUE TO Metastatic Neuroblastoma (C) —		INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 mos.
19. 193.2/11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-4-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnostic biopsy		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1968 to Nov. 2, 1968, that (I) (we) last saw the deceased alive on Nov. 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jess G. Thoene M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 11-2-68.	
23C. PHYSICIAN'S NAME (Type) Jess G. Thoene		23D. ADDRESS 601 N. Broadway, Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION Balto Md		24E. (City, town, or county) (State) # 21217			
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Ruth E. Johnson		25C. FUNERAL DIRECTOR Choy Wilson or Brantley	



68-11149

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11149

REG. NO.

BIRTH NO.

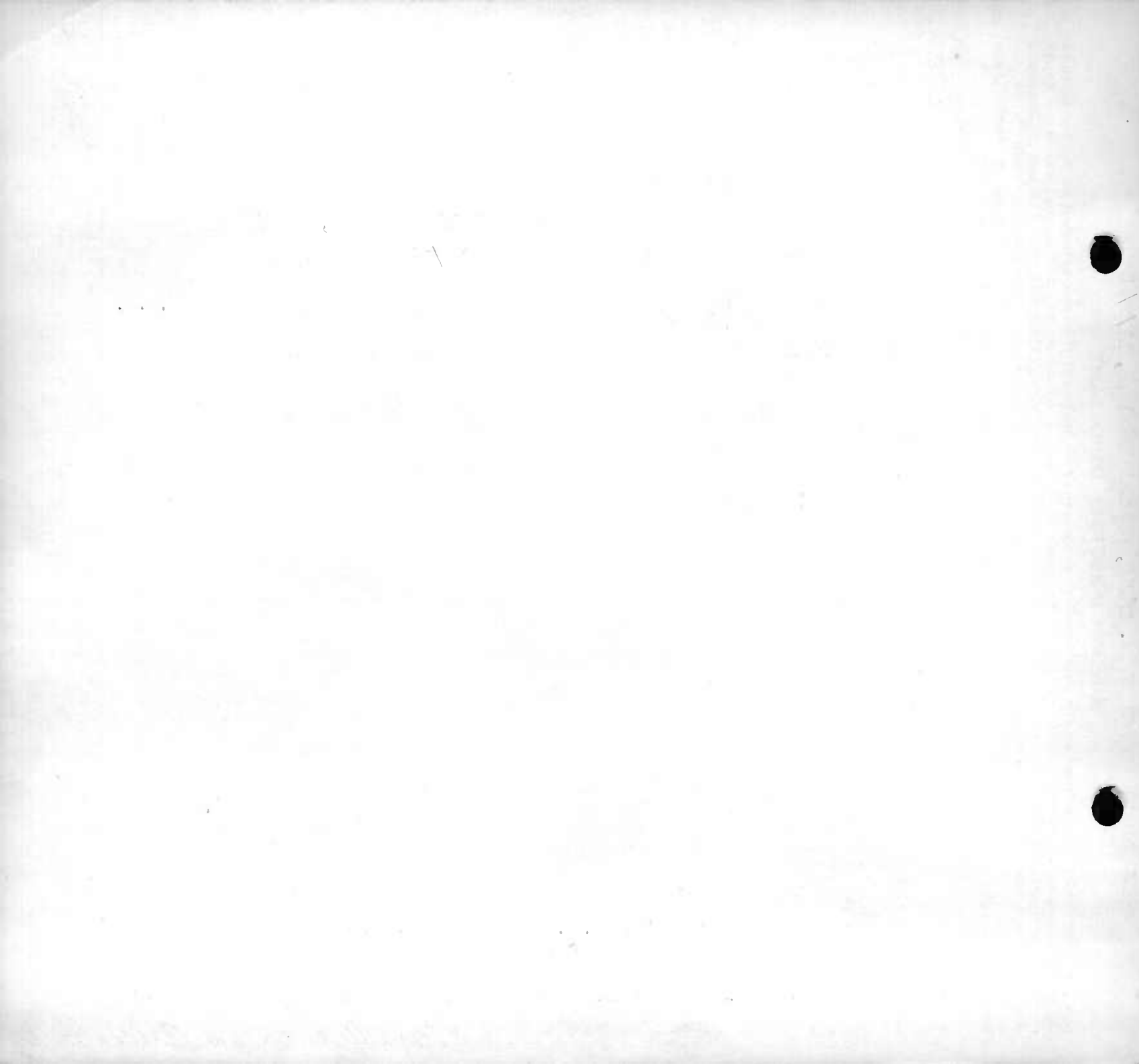
1. NAME OF DECEASED (Type or Print) WILLIE LEE HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 1, 1968 Hour 11:20 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour November 1, 1968 11:20 A.M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 9 - 1945		10. AGE (In years last birthday) 23	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Richard A Harris Sr		15. MOTHER'S MAIDEN NAME Margaret Grammer	
18. INFORMANT Richard A Harris Jr		ADDRESS 1767 Darley Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E965X		CAUSE OF DEATH Gunshot Wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E981X		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) unknown	
22D. TIME OF INJURY (APPROX.) 11/1/68 1:20 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2208 Harford Road		22F. HOW DID INJURY OCCUR? subj. shot in abdomen	
21. AUTOPSY? (Yes or No) No			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 11-6-68	
24C. NAME OF CEMETERY or CREMATORY not at home		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Erroy Wilson	
25C. FUNERAL DIRECTOR Erroy Wilson		ADDRESS 1000 B. County	

James M. Cox

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 68-11150	
BIRTH NO. 68-11150				CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BOWERS, SHIRLEY Alston				2. DATE AND HOUR OF DEATH 11-2-68 8 50 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 1115 Broadway, 21205	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 2/19/36	9. AGE (In years lost birthday) 32	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto Md
13. FATHER'S NAME AUSTIN RILEY			14. MOTHER'S MAIDEN NAME NELLIE RICHARDSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Nellie Richardson - 1639 at St H
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio-respiratory arrest secondary to acute MI Severe Metabolic acidosis Pancreatitis, C.I. bleed			INTERVAL BETWEEN ONSET AND DEATH 12 hr 12 hr 24-36 hr		
19A. DATE OF OPERATION 6-87-0 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul Redstone				23B. DATE SIGNED 11-2-68	
23C. PHYSICIAN'S NAME (Type) PAUL REDSTONE, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR John S. Taylor	
25C. FUNERAL DIRECTOR Elroy W. Johnson		25D. ADDRESS 1000 Pennsylvania Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11151

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rudolph Talbott

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1:10 AM

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

428 N. Patterson Pk. Ave.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

1:25 AM

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

M

7. RACE

C

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Sept 3-1935

10. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

428 N. Patterson Pk. Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Cornel Hall

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen Talbott

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give way or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Rudolph Talbott

ADDRESS

Same

19.

E965X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Shotgun wound of head

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E981X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

428 N. Patterson Pk. Ave.

22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11, 3, 1968 1:10 AM

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/3/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11- -68

24C. NAME OF CEMETERY or CREMATORY

Northwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Eugene Wilson

ADDRESS

Baltimore Md

22

Wm. H. H. H. H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11152

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

HARRIS

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

November 1, 1968

UNK

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

232 N. Mount Street (DOA)

11-15-68

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 1, 1968

7:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

232 N. Mount Street

11. BIRTHPLACE (State or foreign country)

Florida

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

215-09-0045

18. INFORMANT

Ada Upde

ADDRESS

Same

19.

712.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes ☒ NO ☐22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/2/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-4-68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

Charles E. Spitz

25C. FUNERAL DIRECTOR

E. H. Wilson 1000 Brantley Ave.

ADDRESS

Letter from M.E.'s office 11-15-68 M.H.

11-15-68

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11153 CERTIFICATE OF DEATH

REG. NO.

68-11153

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LILLIAN E. DORN		November 2, 1968 3:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 3503 Hudson St. Baltimore, 21224, Md.				Md. Baltimore 53-00 C. CITY OR TOWN Middle River D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box No. 533 D. Rt. 1. Balto., 21221, Md.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1888	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Conrad Klass		14. MOTHER'S MAIDEN NAME Elizabeth Hamer.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry C. Dorn : Box # 533 Rt. 1. Balto. 21, Md.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C.V. Dis. 10-20/15. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
422.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/5 to 11/2 1968, that (I) (we) last saw the deceased alive on 11/2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Highstein				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) Benjamin Highstein				23D. ADDRESS 121 S. Highland Ave., Balto., 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION 7401 German Hill Rd., Ba. Co., Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 7 1968		24F. NAME OF REGISTRAR Regina E. Johnson	
24G. FUNERAL DIRECTOR Charles J. Zeiler		24H. ADDRESS 901 S. Conkling St. Balto., 21224, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11154

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Magness, Stephen Lee, Dr.		November 4th 1968 10:35 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkens Aves. 21229		Maryland Baltimore		53-00	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER		21 Overhill Road Catonsville 28	
5. SEX m	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1911	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY Taylor Manor Nursing Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Samuel Lee Magness		14. MOTHER'S MAIDEN NAME Stella F. McConnell		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes I W.W. II		16. SOCIAL SECURITY NO. 219-38-1910		17. INFORMANT Mrs. Edna C. Magness-21 Overhill Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH Resolving infarct of D. ventricle and interventricular septum (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe occlusive coronary arteriosclerotic disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOV. 4 1968 to NOV. 4 1968, that (X) (we) last saw the deceased alive on NOV. 4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles J. Lancelotta, MD				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) Charles J. Lancelotta, for Barnett Berman MD.- P12-6187				23D. ADDRESS ST AGNES HOSPITAL-BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/7/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery- Baltimore, Md.	
24D. LOCATION (City, town, or county) (State) Catonsville, Md. 21228		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Charles J. Lancelotta	
25C. FUNERAL DIRECTOR Baltimore Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228		25D. ADDRESS			

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text, possibly a date or a short sentence, located below the first block.

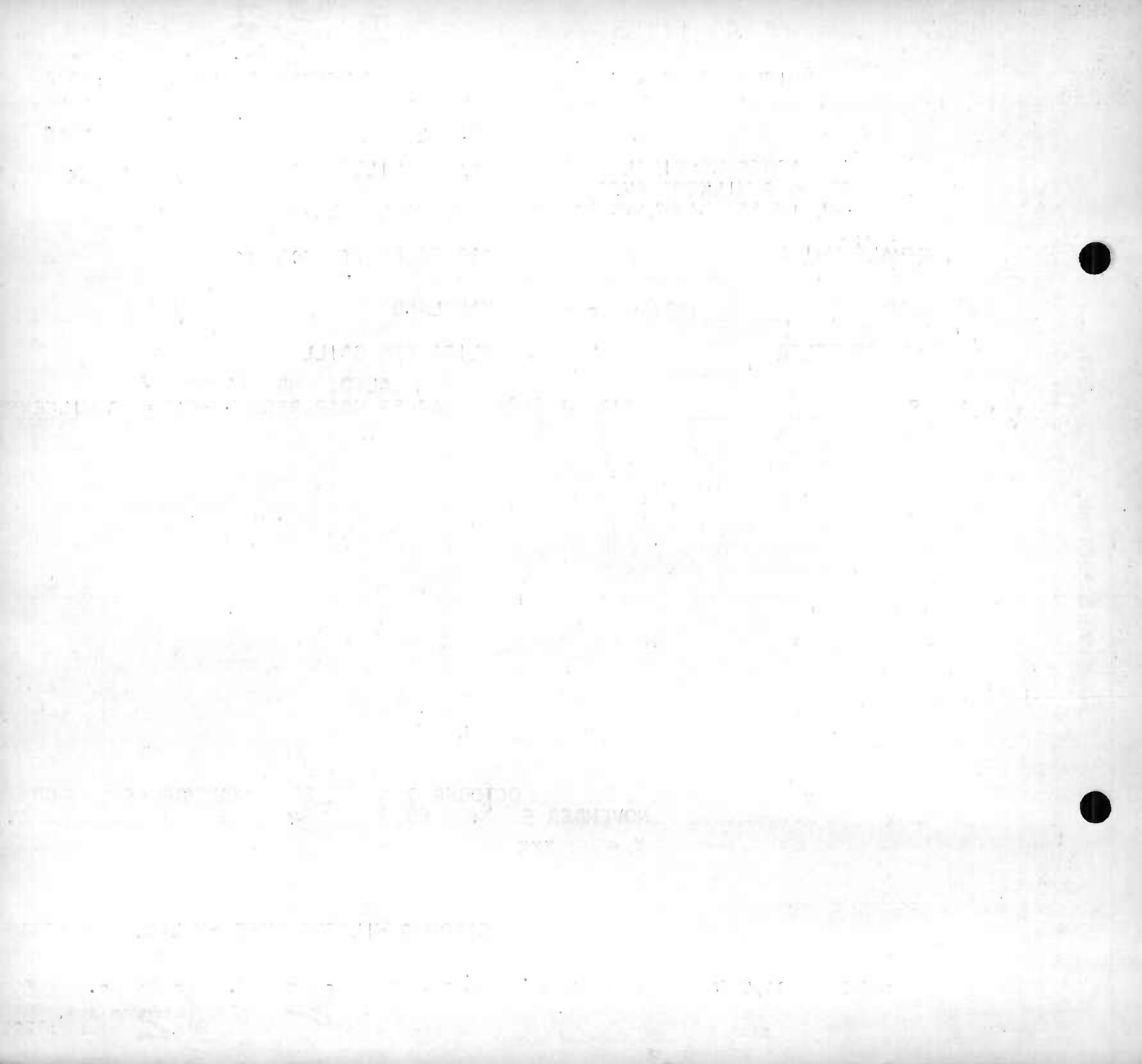
Handwritten text, possibly a signature or name, located in the lower right quadrant.

HBD
K-523
EYE BANK CALLED
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11155 CERTIFICATE OF DEATH

REG. NO. 68-11155

BIRTH NO.		1. NAME OF DECEASED (Type or Print) KNIGHT, ROSE ELLAMAY		2. DATE AND HOUR OF DEATH NOVEMBER 5, 1968 7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CATONSVILLE C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES E. STREET AND NUMBER 329 HARLEM LANE		21228	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 25 85	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Platts Corp		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN SCHEELER		14. MOTHER'S MAIDEN NAME ELIZABETH GRILL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 01 8489		17. INFORMANT BALTO., MD. 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1st & 3rd degree burns (35 % body) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E916.7 II		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 10-7-68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 5:10 P.M. 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 329 Harlem Lane 53-00 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10-7-68 5:10 P.M. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? carpal tunnel, like leg fell on body, twisted & caught fire		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 7 1968 to NOVEMBER 5 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOVEMBER 5 1968 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.		23A. SIGNATURE Jane V. del Pilar DEGREE _____ 23C. PHYSICIAN'S NAME (Type) CATON & WILKENS AVES.-BALTO., MD. 21229		23B. DATE SIGNED NOV 7 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/7/68		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) (State) Dorsey, Md. Howard Co.		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR 17th St. City Hall	
25C. FUNERAL DIRECTOR 237 Patapsco Ave. 21225		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11156

CITY OF BALTIMORE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

REG. NO.

68-11156

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MEYER, JOSEPH JOHN Sr.		2. DATE AND HOUR OF DEATH NOVEMBER 5, 1968 1 5:42 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS & CATON AVENUES			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 912 WILMINGTON AVENUE		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME OTTO, MEYER			14. MOTHER'S MAIDEN NAME (UHLMAN) LOUISE ULLMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO Yes World War I		16. SOCIAL SECURITY NO. 705-03-6939		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL-WILKENS & CATON AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory arrest. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Central Thrombosis- (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.U.D. (C) Progressive muscular dystrophy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH + 6 years -	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 11-5-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural hematoma - R/O. Hematoma		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from NOVEMBER 5, 19 68 to NOVEMBER 5, 19 68 , that XX (we) last saw the deceased alive on NOVEMBER 5, 19 68 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XXXX view the body after death.					
23A. SIGNATURE Alexandro Mejia DEGREE MD				23B. DATE SIGNED 11 05 68	
23C. PHYSICIAN'S NAME (Type) ALEXANDRO MEJIA				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-68		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Dorsey Rd. Howard Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Alfred E. Sisk		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

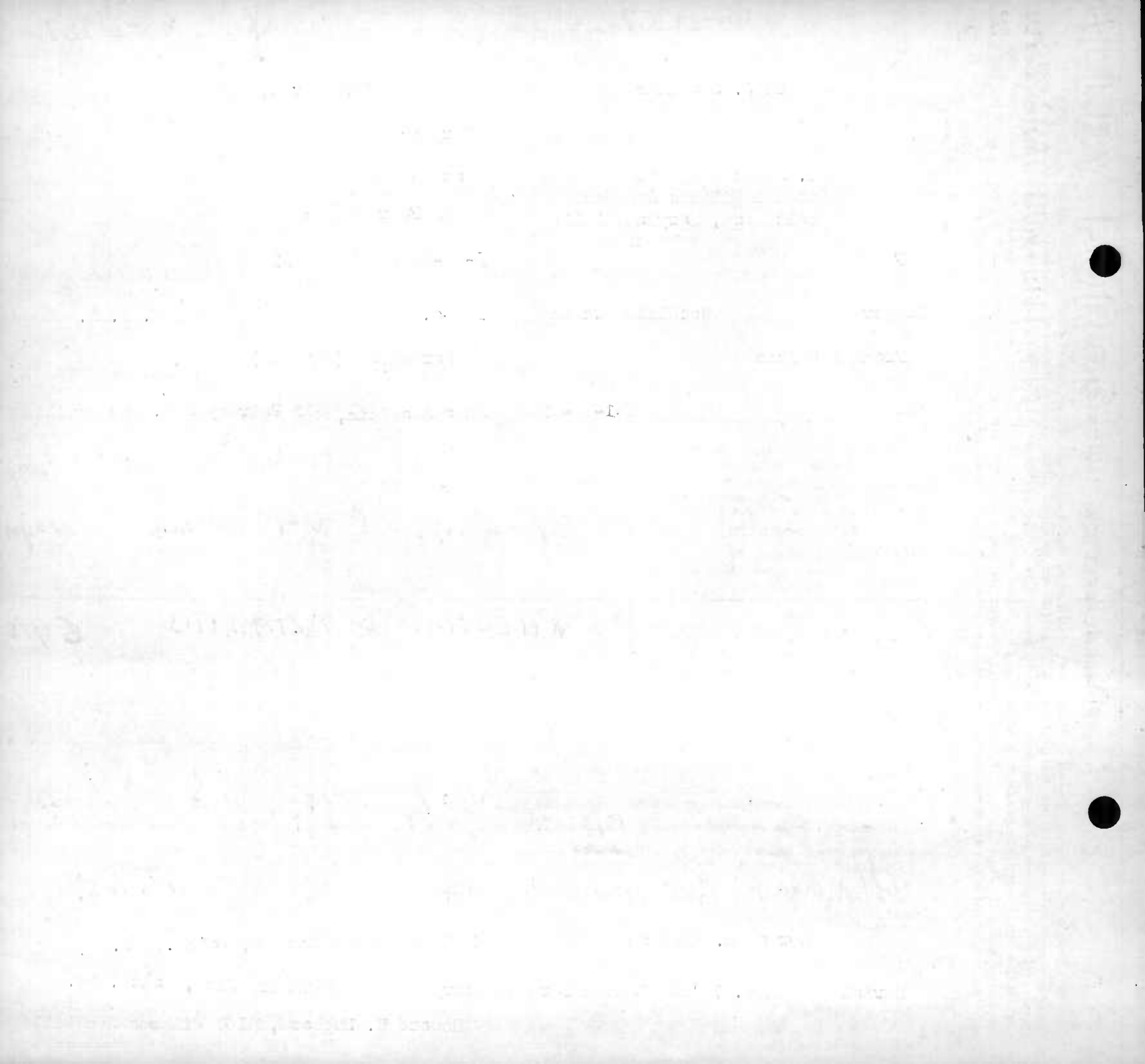
68-11157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11157

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Albert J. Adamitis		2. DATE AND HOUR OF DEATH November 3, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenues Baltimore, Maryland 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto 53-00		5. CITY OR TOWN Catonsville	
6. DATE OF BIRTH 5-10-1915		7. AGE (In years last birthday) 53		8. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. SEX F		10. RACE W		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		13. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		14. BIRTHPLACE (State or foreign country) Penna.	
15. FATHER'S NAME Frank Adamitis		16. MOTHER'S MAIDEN NAME Marcella (Unknown)		17. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		19. SOCIAL SECURITY NO. 181-09-0344		20. INFORMANT Anna Adamitis, 813 Fairway Ave., Catonsville	
21. CAUSE OF DEATH 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY THROMBOSIS - 1 day 420.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive C-V-R Disease - 10 yrs 420.11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). RHEUMATOID ARTERITIS 6 yrs		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE CORONARY THROMBOSIS - 1 day		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
24. DATE OF OPERATION 420.11		25. CONDITION FOR WHICH OPERATION WAS PERFORMED II		26. AUTOPSY? (Yes or No) NO	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 5/15/68		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR? 11/3/68	
33. I certify that (I) (the hospital) attended the deceased from 5/15/68 to 11/3/68 , that (I) (we) last saw the deceased alive on 10/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
34. SIGNATURE Norman R. Kleiman		35. DATE SIGNED 11/5/68		36. PHYSICIAN'S NAME (Type) Norman R. Kleiman	
37. BURIAL CREMATION, REMOVAL (Specify) Burial		38. DATE Nov. 7 '68		39. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
40. DATE REC'D BY HEALTH DEPT. NOV 7 1968		41. NAME OF REGISTRAR Robert E. Jenkins		42. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave 21229	



FUNERAL DIRECTOR: IMPORTANT

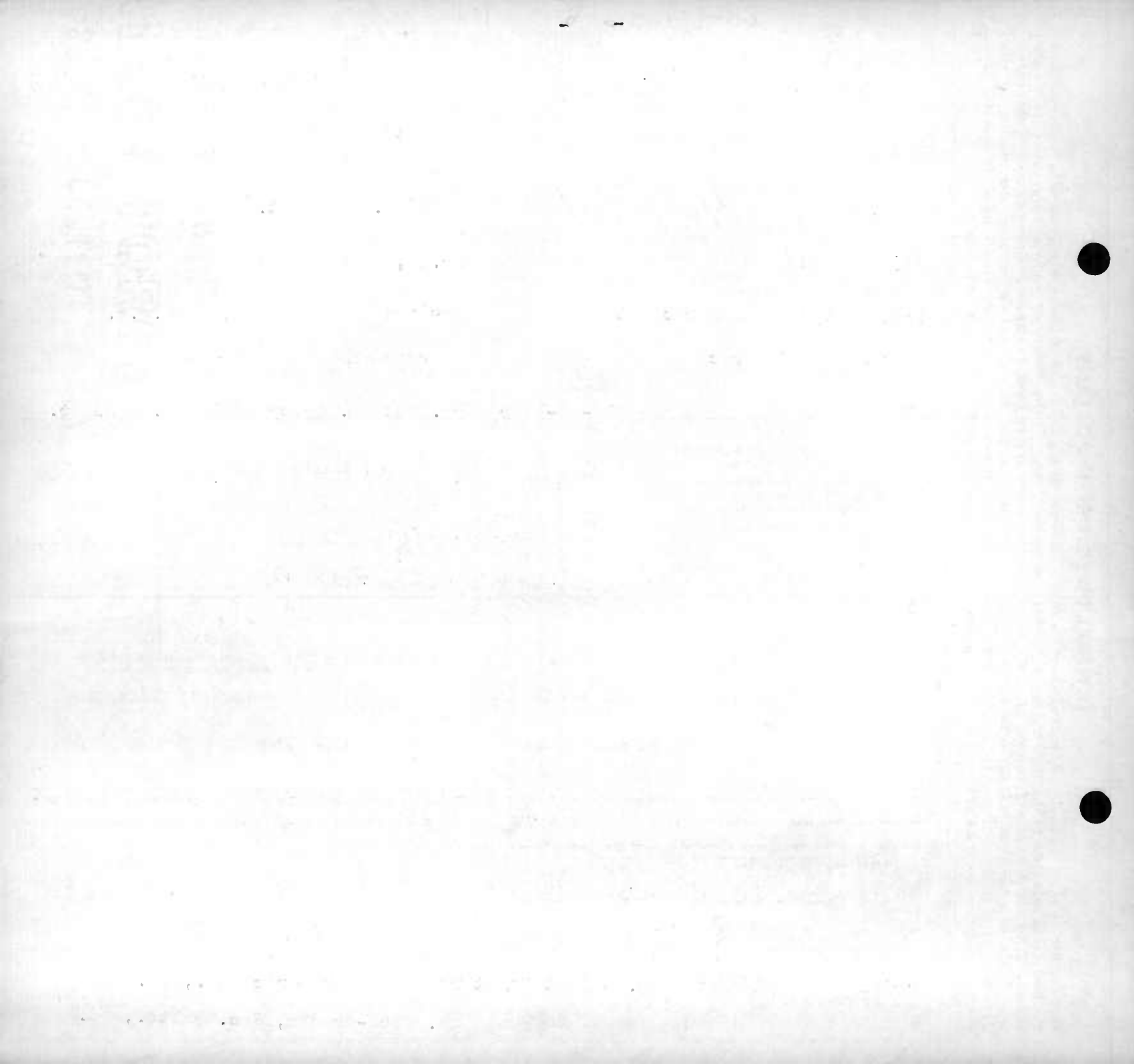
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11158-

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11158

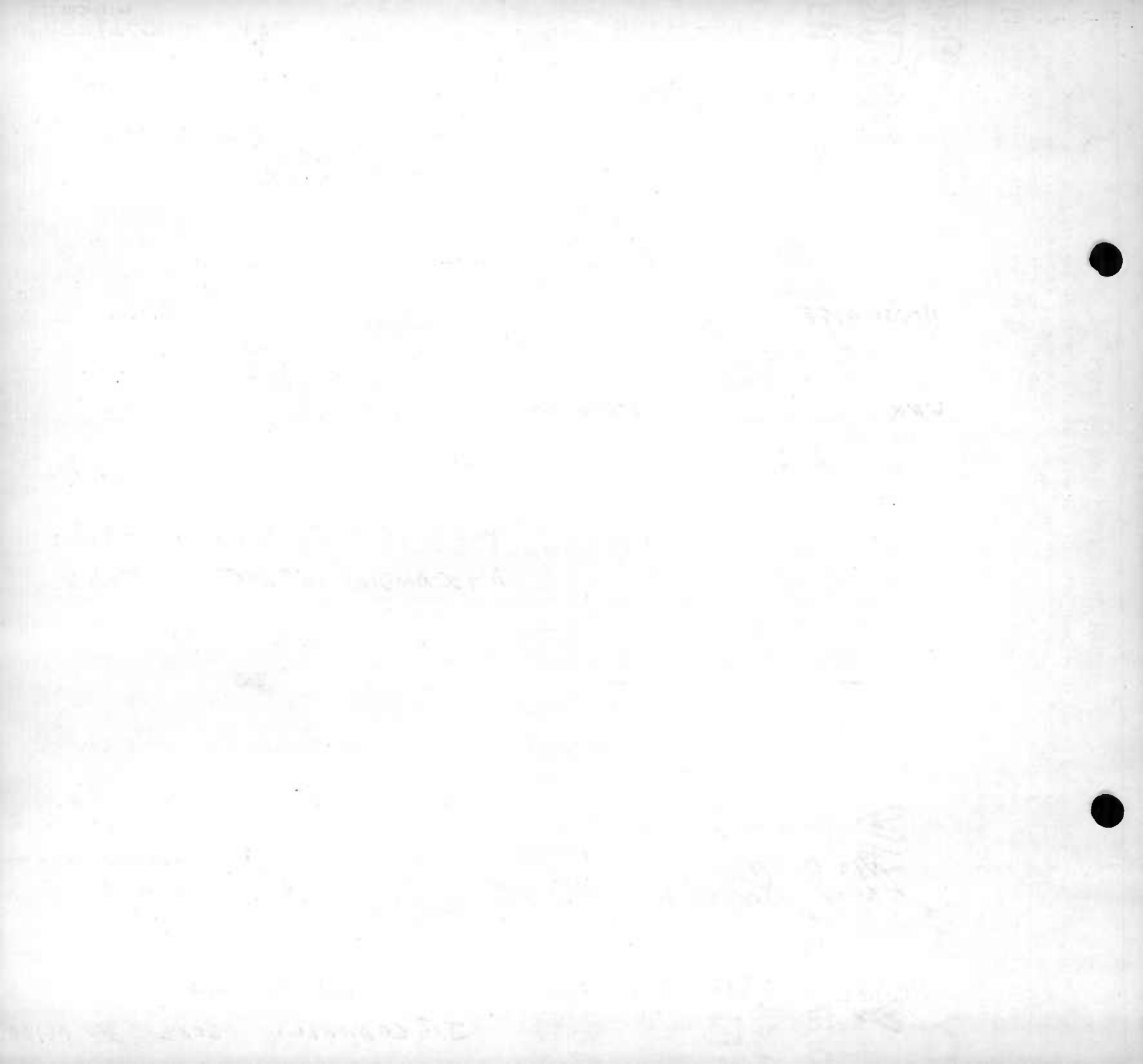
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RALPH J. TRACY		2. DATE AND HOUR OF DEATH 5 NOV 68 11:39 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 77 Mercy Hospital.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-06		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 77 Mercy Hospital.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1626 E. 32 nd St.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 1914	9. AGE (In years lost birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) transporter		10B. KIND OF BUSINESS OR INDUSTRY Armco Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Harris Tracy			14. MOTHER'S MAIDEN NAME Mary Oden		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 24-10-3425		17. INFORMANT Mrs. Ruth L. Tracy 1626 W E. 32nd St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension Nephrolithiasis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 682X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4 NOV 19 68 to 5 NOV 19 68 , that (H) (we) last saw the deceased alive on 5 NOV 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Salvatore R. Donohue MD				23B. DATE SIGNED 5 NOV 68	
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE MD		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION Frederick Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Robert E. Salzman		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520		68-11159		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11159	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) KUNNS, MABEL C			
2. DATE AND HOUR OF DEATH 11/4/68 10:48 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. 53-00			
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8-11-06 9. AGE (In years last birthday) 62			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) NEBRASKA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME BEN BENGTSON				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO. 505-01-4974			
17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE #21224				18. DATE OF OPERATION 2 - 19. CONDITION FOR WHICH OPERATION WAS PERFORMED -			
19A. DATE OF OPERATION 2 -				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/2/68 19 68 to 11/4/68 19 68, that (I) (we) last saw the deceased alive on 11/4/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Robert Rosenbaum, MD			
23B. DATE SIGNED 11/4/68				23C. PHYSICIAN'S NAME (Type) ROBERT ROSENBAUM M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 11/6/68			
24C. NAME OF CEMETERY or CREMATORY HOLLY HILL				24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968				25B. NAME OF REGISTRAR Robert E. Salyer			
25C. FUNERAL DIRECTOR J.E. CONNELLY				25D. ADDRESS 505 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>8-11160</u>	
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
SELBY, CHARLES ENSOR		NOVEMBER 3, 1968 6:35 A/ M.		FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
MARYLAND		CLARKSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. STREET AND NUMBER		8. DATE OF BIRTH		9. AGE (In years last birthday)	
OAKCREST LANE		11/23/95		72	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
INTERIOR DECORATOR		MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
ALBERT SELBY		ANNIE MUSGROVE		YES WORLD WAR 1	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218 18 1596		BALTO MD 21229		ST AGNES' RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>severe dehydration + uremia</u> <u>Chronic disease type unknown</u> <u>Acute Renal failure</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <u>Severe pneumonia</u>		T week (?) ?	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No)	
0		NO		NO	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME OF INJURY (APPROX.)		28. INJURY OCCURRED		29. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 2</u> 19 <u>68</u> to <u>NOVEMBER 3</u> 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>NOVEMBER 3</u> 19 <u>68</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<u>Robert Widmeyer MD</u>		11/3/68		ROBERT WIDMEYER MD	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
ST AGNES HOSPITAL CATON & WILKENS AVE		burial		11/6/68	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.	
Mt. View		Alpha, Howard Md.		NOV 7 1968	
24F. NAME OF REGISTRAR		24G. FUNERAL DIRECTOR		24H. ADDRESS	
Robert E. Taylor		John R. Slack		Higinbotham Slack Ellicott City Md	

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF THE CENSUS
ON THE
CENSUS OF 1900

CHAPTER I
GENERAL PRINCIPLES
OF THE CENSUS

SECTION I
THE CENSUS OF 1900
IN THE UNITED STATES

SECTION II
THE CENSUS OF 1900
IN THE DISTRICT OF COLUMBIA

SECTION III
THE CENSUS OF 1900
IN THE TERRITORIES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MAREK, LOUIS JOHN--		11/5/68 10:12 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF DECEASED HOSPITAL OR INSTITUTION				A. STATE B. COUNTY	
8C UNIVERSITY OF MARYLAND HOSP GREENE & LOMBARD, BALT.				Md 25-04	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		Cauc		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
Maint Supervisor		AMERICAN OIL CO		Md (Baltimore)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MAREK ALBERT			Stack		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
UNKNOWN No			UNKNOWN		
17. INFORMANT			ADDRESS		
Mrs. Estella Marek			3547 3rd St. 21225		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				ACUTE BLOOD LOSS 1 HOUR	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				RUPTURED THORACIC ANEURYSM 8 HOURS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
11/5/68				RUPTURED THORACIC ANEURYSM	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/5 19 68 to 11/5 19 68, that (I) (we) last saw the deceased alive on 11/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				11/5/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				University of Md Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/8/68		Cedar Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
11/8/68		[Signature]		McCully F. H. 237 Patapsco Ave. 21225	

11-11-68

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11162	
1. NAME OF DECEASED (Type or Print) ADAMS, Harold Jerome				2. DATE AND HOUR OF DEATH 11-3-68 12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Parkville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2609 Ivy Place	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-08	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10B. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/10/43 - 2/17/46		
16. SOCIAL SECURITY NO. 117-07-2495			17. INFORMANT VA Hospital Records Baltimore, Maryland 21218		
18. 410.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease 4 years Chronic congestive heart failure 2 weeks				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 16, 1968 to November 3, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 3, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Marvin C. Mengel M.D.				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) MARVIN C. MENGEL, M.D.				23D. ADDRESS 3900 Loch Raven Blvd. Baltimore, Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-68		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968			
25B. NAME OF REGISTRAR Johnson		25C. FUNERAL DIRECTOR Johnson Funeral Home 8521 Loch Raven Blvd.			

1357

— 1 —

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
68-11163 CERTIFICATE OF DEATH**

REG. NO. **68-11163**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Smith, Anna Marie</i>		2. DATE AND HOUR OF DEATH <i>9pm - 11-4-68</i> 9 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Balto. Gen. Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>AM</i> 6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-27-02</i> 9. AGE (In years last birthday) <i>65 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>John Schuck</i>		14. MOTHER'S MAIDEN NAME <i>Modeline Frankless</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph B. Smith 19 W. West St.</i> ADDRESS	
18. <i>450X1-174X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Unknown</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) <i>Ca - breast</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>10-30</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> 19 <i>68</i> to <i>11-4-68</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-4-68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. G. Bannan</i> DEGREE		23B. DATE SIGNED <i>11-4-68</i>		23C. PHYSICIAN'S NAME (Type) <i>C. G. BANNAN M.D.</i> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/8/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Old Frederick Rd. Balto. Md</i>		24E. STATE (State) <i>Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 7 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>KRAUSE FUNERAL HOME</i>		25D. ADDRESS <i>1216S. Charles</i>	

10-1

Interim Report

Interim Report

Mr. Frost

11-11-11

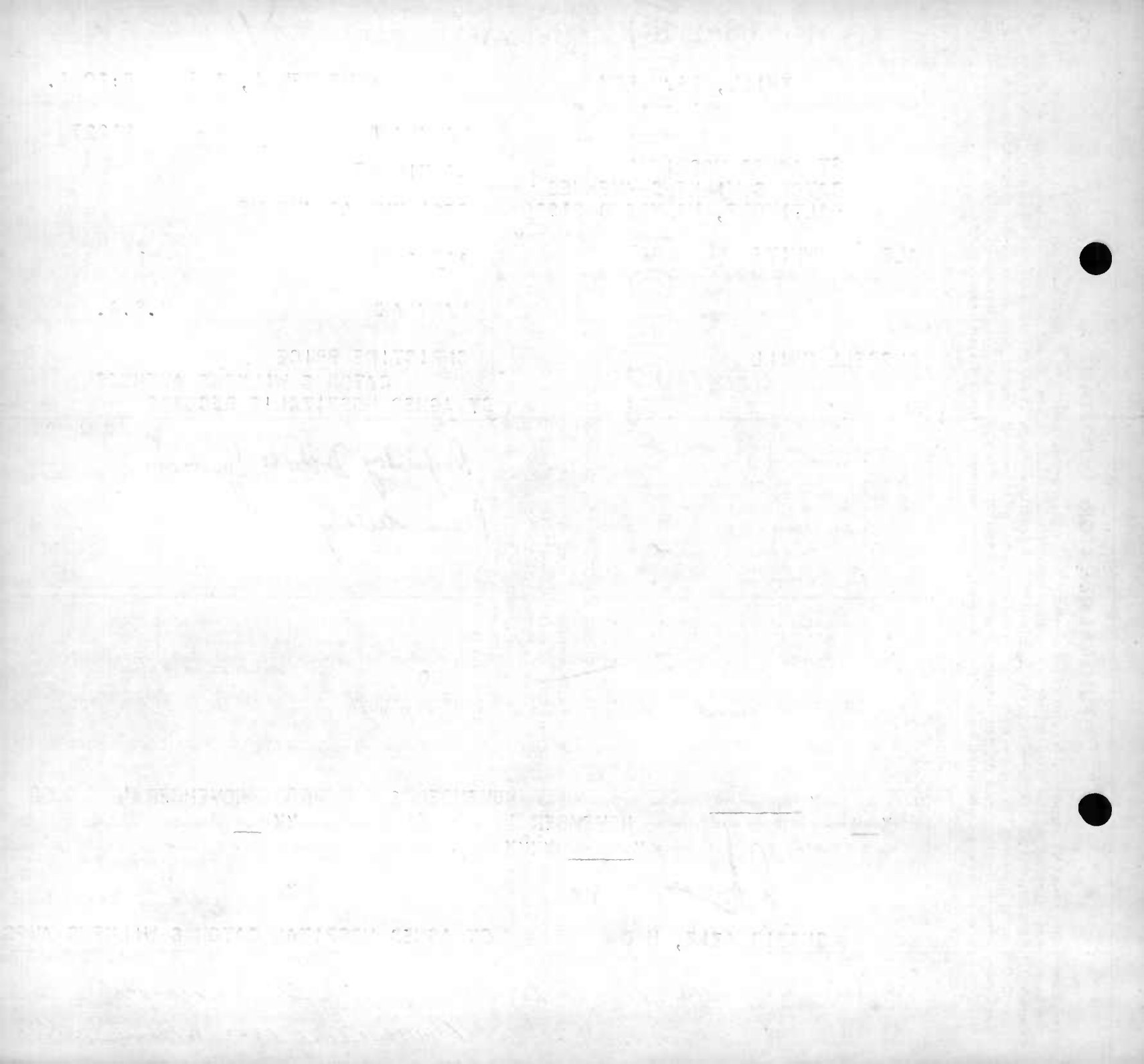
Interim Report

C. D. Edwards

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>68-21194</u> <u>68-11164</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-11164</u>
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
<u>KNILL, BABY BOY</u>		<u>NOVEMBER 4, 1968</u> <u>5:30 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> <u>ST AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5524 THOMAS AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/03/68</u>	9. AGE (In years last birthday) <u>1</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>RUSSELL KNILL</u>		
14. MOTHER'S MAIDEN NAME <u>CHRISTINE PRICE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CATON & WILKENS AVENUES</u> <u>ST AGNES HOSPITAL'S RECORDS</u>		
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTecedent CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>773.5 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Respiratory Distress Syndrome</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u> (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>NOVEMBER 3</u> 19 <u>68</u> to <u>NOVEMBER 4</u> 19 <u>68</u> , that <u>(X we)</u> last saw the deceased alive on <u>NOVEMBER 4</u> 19 <u>68</u> and that in <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(XXXX)</u> view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>Nov. 4, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>SHADID AZIZ, M D</u>
23D. ADDRESS <u>ST AGNES HOSPITAL CATON & WILKENS AVES</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Nov 5, 1968</u>		
24B. DATE <u>Nov. 5, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Catholic</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 7 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Amberose Inc. 1325 Sulphur Sp. Rd.</u>



68-11165

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WARFIELD, HENRY N.

2. DATE AND HOUR OF DEATH

NOVEMBER 3, 1968 10:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)ST. AGNES HOSPITAL
WILKENS & CATON AVENUES
BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN

ELLICOTT CITY

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

301 BALTO NAT'L PIKE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

6/25/1892

9. AGE (In years
last birthday)

76

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

Koppers Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry R. Warfield

14. MOTHER'S MAIDEN NAME

Josephine Poole

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL
SECURITY NO.

212 09 8882

17. INFORMANT

BALTO., MD. 21229
ST. AGNES RECORDS CATON & WILKENS AVES

18.

4369 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

331X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

6

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that ~~XX~~ (this hospital) attended the deceased from NOV. 3 19 68 to NOV. 3 19 68,
that ~~XX~~ (we) last saw the deceased alive on NOV. 3 19 68 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~XX~~ (We) (did) ~~XXXX~~ view the body after death.

23A. SIGNATURE

Charles J. Lancelotta, Jr. M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/3/68

23C. PHYSICIAN'S
NAME (Type)

CHARLES J LANCELOTTA, JR M.D.

23D. ADDRESS

ST AGNES HOSPITAL CATON & WILKENS AVES

24A. BURIAL CREMATION,
REMOVAL (Specify)

burial

24B. DATE

11/7/68

24C. NAME of CEMETERY or CREMATORY

Balto. National

24D. LOCATION

Baltimore Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Higinbotham Slack

ADDRESS

Ellicott City, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

WILKINSON & LARSON
BALTIMORE, MARYLAND 21202

14.3

WILKINSON & LARSON
BALTIMORE, MARYLAND 21202

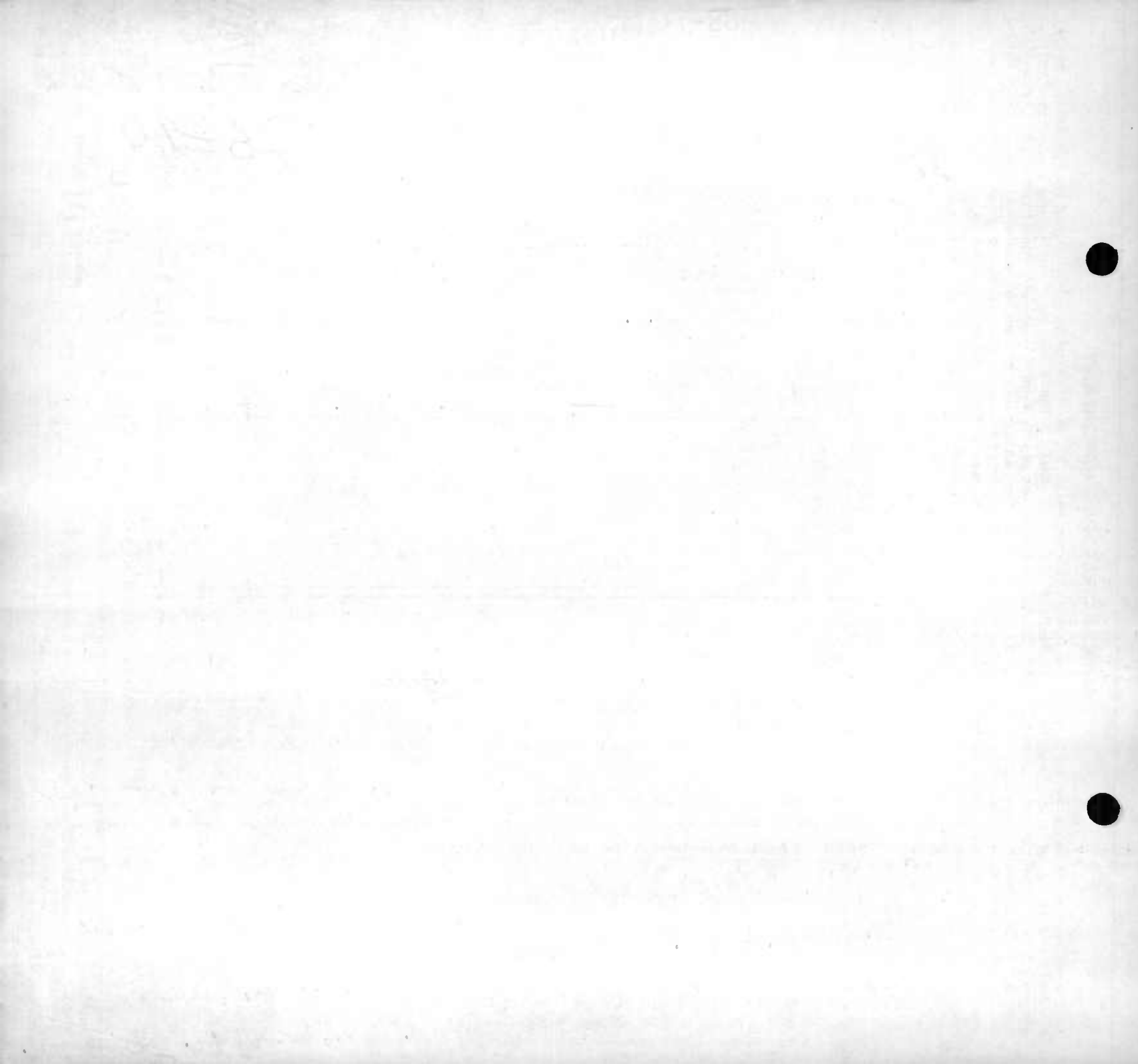
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11166 BALTIMORE CITY HEALTH DEPARTMENT
68-11166 CERTIFICATE OF DEATH

REG. NO. 68-11166

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Fellon Temple</i>		2. DATE AND HOUR OF DEATH <i>November 5, 1968</i> <i>2:36 A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-10</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 City Hospitals</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>2/2/15</i>		9. AGE (In years last birthday) <i>53</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Freight Conductor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Petersburg, Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Temple</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Hare</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT ADDRESS <i>Mrs. Alice G. Temple 3205 Leventon Ave</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial infarction</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary sclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr - 3 yr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>2 nov</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/5 1968</i> to <i>11/5 1968</i> , that (I) (we) lost saw the deceased alive on <i>11/5 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Maurice Feldman, Jr.</i>		DEGREE <i>—</i>		23B. DATE SIGNED <i>11/6/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Maurice Feldman, Jr.</i>		23D. ADDRESS <i>6610 CROSS COUNTRY BLVD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/8/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>Nov 7 1968</i>			
25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i>			



G-363

68-11167 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11167

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD P. GUTRIDGE

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 4, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 4, 1968

6:35 AM

5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

100 W. Baltimore St. (Construction site)

6. SEX

Male

7. RACE

White

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7/17/'12

10. AGE (In years
last birthday)

56

If Under 1 Yr. II Under 24 Hrs.
Months: Days: Hours: Min.

E. STREET AND NUMBER

104 N. Clinton Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward P. Gutridge

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guard

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marie Trainor

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-04-2513

18. INFORMANT

ADDRESS

Mrs. Elizabeth Gutridge 104 N. Clinton St

19. 412.4
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH
Arteriosclerotic cardiovascular diseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/8/68

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery, Baltimore, Maryland

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

11/8/68

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

John A. Moran, Inc. 3000 E. Baltimore St

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

NOV 1941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11168

BIRTH NO. 68-18022

1. NAME OF DECEASED
(Type or Print)

MARK BROWN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 3, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 3, 1968

11:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-24-68

10. AGE (In years
last birthday)

6 weeks

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

1 1/2

E. STREET AND NUMBER

932 N. Castle Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Willie P. Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Margaret Hightower

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

None

18. INFORMANT

ADDRESS

Margaret Brown 932 N. Castle St.

19.

795X1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Sudden death in infancy
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

7963

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D.

TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-7-68

24C. NAME OF CEMETERY or CREMATORY

National Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 7 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS

9-24-68

Barre, Md.

None

no

Willie F. Brown

Marshall University

Marshall University, 1200 N. 1st St.

Marshall, W. Va.

Barre, Md.

9-24-68

Marshall University

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				88-11169	
BIRTH NO. 2-615				68-11169	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) GRIFFIN ANNIE				2. DATE AND HOUR OF DEATH Nov 2, 1968 15:36 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 827 N. WASHINGTON STREET	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-2-09	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Athens, Ga.	
13. FATHER'S NAME CASPER BERRY			14. MOTHER'S MAIDEN NAME LAURA KEITH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT BENJAMIN GRIFFIN
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 205.1 I			CAUSE OF DEATH (A) Subarachnoid hemorrhage DUE TO (B) Chronic myelogenous leukemia DUE TO (C) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 42 hrs 2 yrs many yrs
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 204.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-31 19 68 to 11-2 19 68 , that (I) (was) last saw the deceased alive on 11-2 19 68 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank C. Arnett				23B. DATE SIGNED 11/2/68	
23C. PHYSICIAN'S NAME (Type) FRANK C. ARNETT				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cmt.	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Randolph J. Collick			
25D. ADDRESS 2431 E. Oliver St.					

PC

78

Handwritten text, likely a list or notes, mostly illegible due to fading.

Handwritten text, likely a list or notes, mostly illegible due to fading.

Handwritten signature or name, possibly "Frank [illegible]".

11/1/18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11170

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Martha Mills		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 2 1968 4:52 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 1968 4:52 PM	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
6. SEX F	7. RACE C	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 3-25-1905		10. AGE (In years lost birthday) 65	E. STREET AND NUMBER 1824 Durham Street
11. BIRTHPLACE (State or foreign country) Nashville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Lee Lucas
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY At home	15. MOTHER'S MAIDEN NAME Tollie Drake
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	18. INFORMANT Roger Mills 1824 N. Durham St.
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 4/2/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11-6-68		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 11/3/1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE 11-6-68	24C. NAME of CEMETERY or CREMATORY Union Hill Cemetery	24D. LOCATION (City, town, or county) (State) Nashville, N.C.
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968	25B. NAME OF REGISTRAR Robert S. Bailey	25C. FUNERAL DIRECTOR Randolph J. Collick	ADDRESS 2431 E. Oliver St.

3-22-1902

Nashville, N.C. Lee Lewis
Domestic Nelson
Tollie Drake

Robert Lee Lewis, Jr.

Handwritten signature

Removal W-6-68 Union Hill Cemetery, Nashville, N.C.

Joseph H. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 68-11171	
BIRTH NO. 6-653		68-11171		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Zan Barnett			2. DATE AND HOUR OF DEATH November 1 1968 11:46 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			A. STATE Maryland B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2011 Boone St. 1017 Wilmot Ct. 21202			E. ZIP CODE 21202		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-24-00	9. AGE (In years last birthday) 68	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Roxboro, N.C.	
13. FATHER'S NAME Willie Barnett			14. MOTHER'S MAIDEN NAME Agnes Street		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-07-0094		
17. INFORMANT Mrs. Lucy M. Barnett			ADDRESS 1017 Wilmot Ct.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest			INTERVAL BETWEEN ONSET AND DEATH 90 minutes		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension			15 years		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 443X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1957 to 11/1 1968 , that (I) (we) lost saw the deceased alive on 11/1/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey D. Neill				23B. DATE SIGNED 11/1/68	
23C. PHYSICIAN'S NAME (Type) Jeffrey D. Neill, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Carver Memorial PK. Laurel Md.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR Randolph J. Collick		24F. FUNERAL DIRECTOR ADDRESS 273 E. Oliver St.	

November 1 1968 11:45 AM

San Barnett

4-4-00 08

M M

Cardiac Arrest

Hypertension

12 years

yes

11/11/68 21 11 11

Ther. P. R. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11172	
D-670 68-11172		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edgar Durphrey or Durphen</i>		2. DATE AND HOUR OF DEATH <i>10/27/68</i> <i>9:00</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI Hospital</i> <i>42</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3800 SEQUOIA AVE</i>					
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-88</i>	9. AGE (In years lost birthday) <i>81</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bessie Williams</i>	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>ARRhythmia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>POSS. ACUTE M.I.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ASCVD = Hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>September 1967</i> to <i>October 1968</i> , that (I) (we) last saw the deceased alive on <i>10/25</i> <i>19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gerald B. Feldman MD</i>		23B. DATE SIGNED <i>10/27/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>GERALD B. FELDMAN, MD</i>		23D. ADDRESS <i>SINAI Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/1/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bald Natl Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>5501 Frederick Ave Baltimore</i>					
25A. DATE REC'D BY HEALTH/DEPT. <i>NOV 7 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Frederick T. [illegible]</i>	
ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-11173		Registered No. 68-11173	
BIRTH NO. <u>W-300</u>		68-11173		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 11/1/68 3PM	
1. NAME OF DECEASED (Type or Print) <u>ary White</u>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 Johns Hopkins Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Chase</u> D. STREET ADDRESS (If rural, give location) <u>53-00 Eastern Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>April 1917</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Suffolk Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John array</u>		14. MOTHER'S MAIDEN NAME <u>Sadie</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Matthew White</u>		ADDRESS					
18. <u>251X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypoglycemia</u>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>11 weeks</u>	
				(B) DUE TO		<u>11 weeks</u>	
				(C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>270X II</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/1/68</u> to <u>11/1/68</u> and that (I) (we) last saw the deceased alive on <u>11/1/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Kevin Hennessey</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>11/1/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>Kevin N. Hennessey</u>		23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov 6/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sharp Street Com</u>		24D. LOCATION (City, town, or county) (State) <u>Chase Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 7 1968</u>		25B. NAME OF REGISTRAR <u>R. E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Melton E. Elckorn</u>		ADDRESS <u>11377</u>	

James Howard

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11174	
BIRTH NO. 4-620		68-11174 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Ellen E. Harris		2. DATE AND HOUR OF DEATH October 25, 1968 1 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1630 E. Federal St.		F. STREET AND NUMBER 1630 E. Federal Street	
5. SEX Female	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1908 9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Harris		ADDRESS 1630 E. Federal St.	
18. 4-10-9-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Atherosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (C) 6 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 42011 II Cerebral Thrombosis		6 mos	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-1-1963 to October 25, 1968 , that (I) (we) last saw the deceased alive on 9-23-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.			
23A. SIGNATURE Charles R. Venter, M.D.		23B. DATE SIGNED 10-26-68	
23C. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.		23D. ADDRESS 2320 Eutaw Pl Balto, Md 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 30/68	
24C. NAME OF CEMETERY or CREMATORY Bald Hill Cem.		24D. LOCATION (City, town, or county) (State) 5501 Federal Ave	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Frank E. Eichen		ADDRESS 1129 N. Calhoun	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-232		68-11175		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11175	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Bostic, Tomi or Tommie Jane</i>			
2. DATE AND HOUR OF DEATH <i>11/4/68</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>11/45 P. M.</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY				5. FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND #21224</i>			
6. CITY OR TOWN <i>BALTIMORE</i>				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <i>928 NORTH EDEN STREET #21205</i>							
9. SEX <i>FEMALE</i>		10. RACE <i>NEGRO</i>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH <i>8-18-80</i>	
13. AGE (In years last birthday) <i>88</i>		14. II Under 1 Yr. Months: Days: Hours: Min.		15. II Under 24 Hrs. Hours: Min.		16. BIRTHPLACE (State or foreign country) <i>SOUTH CAROLINA</i>	
17. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		18. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		19. KIND OF BUSINESS OR INDUSTRY		20. FATHER'S NAME <i>Thomas Peak</i>	
21. MOTHER'S MAIDEN NAME <i>Annie Jane?</i>		22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		23. SOCIAL SECURITY NO.		24. INFORMANT <i>BALTIMORE CITY HOSPITALS</i> <i>RECORDS: 4940 EASTERN AVENUE #21224</i>	
25. CAUSE OF DEATH 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Failure of Respiration</i> 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>795.0 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) <i>Failure of Respiration</i> (B) (C) 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
26. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>None</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i> 20A. AUTOPSY? (Yes or No) <i>YES</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <i>YES</i> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NA</i> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NA</i> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NA</i> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Aprox.) <i>NA</i> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>NA</i> 21F. HOW DID INJURY OCCUR? <i>NA</i>		22. I certify that (I) (this hospital) attended the deceased from <i>10/22/68</i> to <i>11/4/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <i>J S Cohen</i> DEGREE <i>J S COHEN M.D.</i>		23B. DATE SIGNED <i>11/4/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>J S COHEN M.D.</i>		23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE #21224</i>		24. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov 7 1968</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Westport, Md.</i>		24D. LOCATION (City, town, or county) (State) <i>Westport, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 7 1968</i>		25B. NAME OF REGISTRAR <i>John E. Elickson</i>	
25C. FUNERAL DIRECTOR <i>John E. Elickson</i>		25D. ADDRESS <i>11290 Capital</i>		25E. DATE REC'D BY HEALTH DEPT. <i>NOV 7 1968</i>		25F. NAME OF REGISTRAR <i>John E. Elickson</i>	

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1
J-525 68-11176 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-11176

BIRTH NO.		1. NAME OF DECEASED (Type or Print) AUDREY JOHNSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour October 28, 1968 1:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3309 Liberty Heights Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour October 28, 1968 1:50 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 11		10. AGE (In years last birthday) 22		E. STREET AND NUMBER 3309 Liberty Heights Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Calvin Hawkins	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Gloria Hawkins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Herbert Johnson	
19. E9551X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot Wound of Chest		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home (bedroom)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3309 Liberty Heights Avenue	
22D. TIME OF INJURY (APPROX.) 10/28/68 1:15 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. shot self in chest	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 10/28/68 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 1/68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph T. Elickson		25D. ADDRESS 129 N. Carroll St.			

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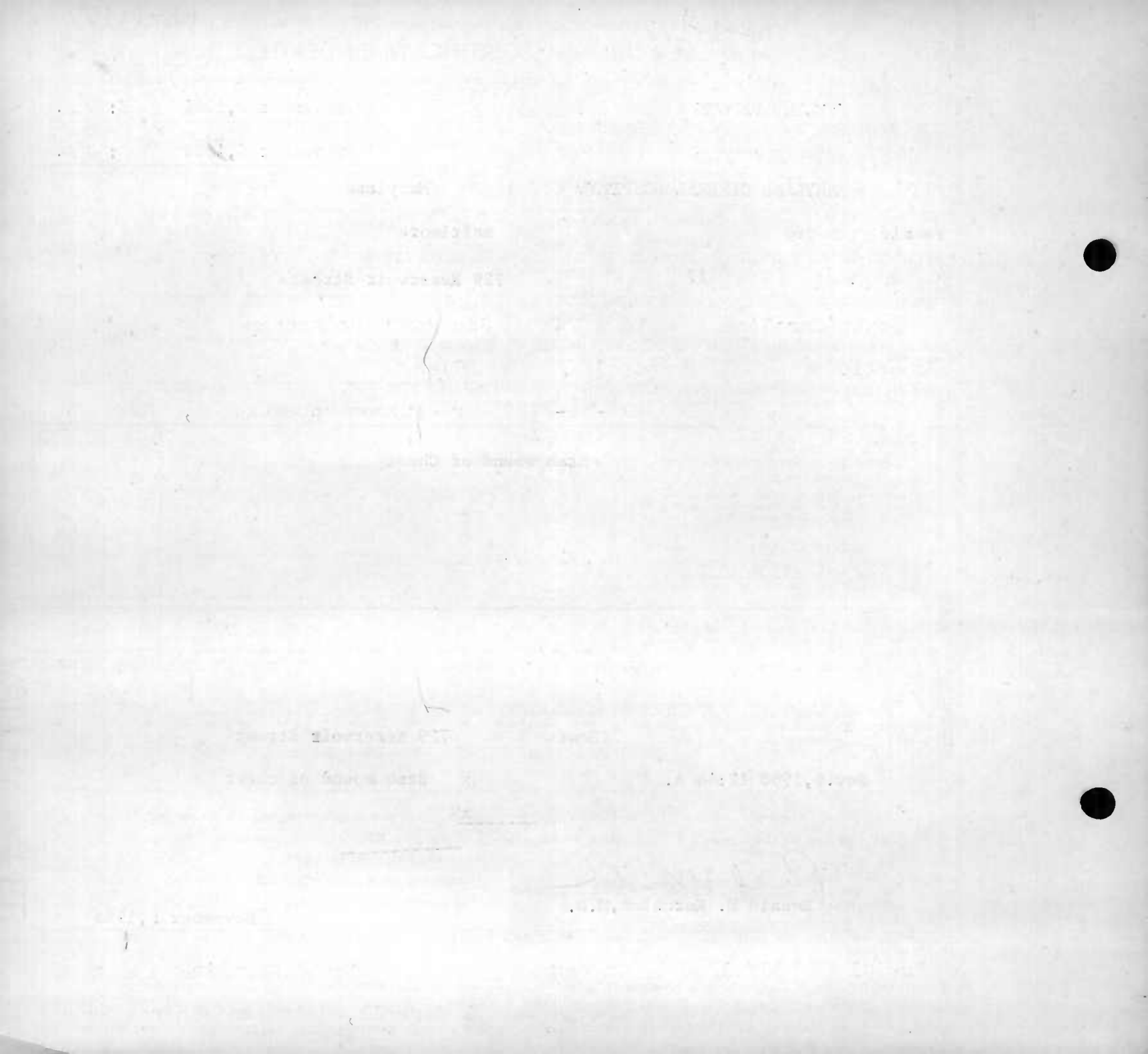
68-11177 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11177

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EVELYN VAUGHN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 6, 1968 3:00 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 6, 1968 3:00 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 3/20/51		10. AGE (In years last birthday) 17	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY Hospital	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		17. SOCIAL SECURITY NO. 218-56-0180	
15. MOTHER'S MAIDEN NAME Ellen		18. INFORMANT Mr Jackson Robertson	
19. E 966 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Stab wound of Chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 6, 1968 12:44 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 729 Reservoir Street 13-02		22F. HOW DID INJURY OCCUR? Stab wound of chest	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 6, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68	
24C. NAME OF CEMETERY or CREMATORY Camden S		24D. LOCATION (City, town, or county) (State) South Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home		ADDRESS 1206 W North Ave	



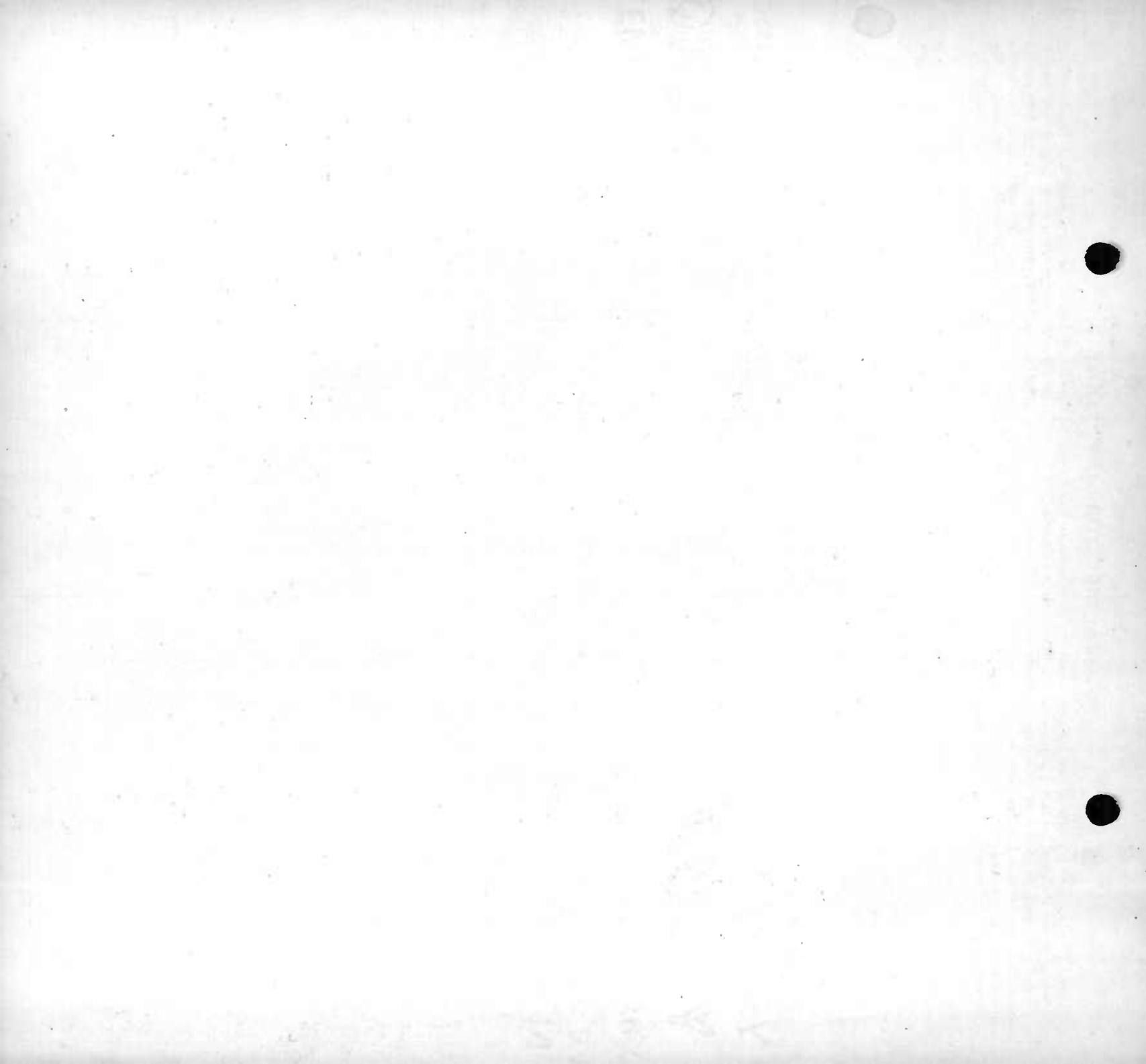
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11178 CERTIFICATE OF DEATH

REG. NO. 68-11178

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIE E DICKSON		11/2/68 1:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2X U S Public Health Hospital			A. STATE Md B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1004 Woodyear St		
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/00	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10B. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Granitville Co S C		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John Dickson			14. MOTHER'S MAIDEN NAME Selena		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W I		16. SOCIAL SECURITY NO. 218-61-6375	17. INFORMANT ADDRESS Mrs Julia Dickson 1717 W Balto. St		
18. CAUSE OF DEATH					
18. 155.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Hepatoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
18. 153.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct 9 19 68 to Nov 2 19 68, that (I) (we) last saw the deceased alive on Nov 2, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey A Githrie			23B. DATE SIGNED 11/2		
23C. PHYSICIAN'S NAME (Typed) Jeffrey A Githrie			23D. ADDRESS U.S. P.H.S. 4108, Balt, Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68	24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, MD
25A. DATE REC'D BY HEALTH DEPT. NOV 7 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Irvin Carroll, Halstead Funeral Home 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11179 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11179

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA M. MYERS		2. DATE AND HOUR OF DEATH November 6, 1968. 28. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines (Belvedere)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1716 S. Charles Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1893	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sales Lady		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Henry Dill			14. MOTHER'S MAIDEN NAME Eleanora Scharff		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-2180		17. INFORMANT Mrs. Charlotte Smith RFD #1 Finksburg Md	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) AC.U.D (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatoid Arthritis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 15 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1967 to Nov 6, 1968 , that (I) (we) last saw the deceased alive on Nov 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul Schinfeld M.D.			23B. DATE SIGNED Nov 7, 1968		
23C. PHYSICIAN'S NAME (Type) Paul Schinfeld M.D.			23D. ADDRESS 2301 Annapolis Rd Baltimore Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/9/68	24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. Nov 7 1968		25B. NAME OF REGISTRAR Phys G. Schinfeld		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

1901

James D. McNeill

Nov 21 1901

Nov 20 1901
40
James D. McNeill

Nov 20 1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11180</u>
BIRTH NO. <u>68-11180</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Jeffrey Raymond Cole		2. DATE AND HOUR OF DEATH Nov. 2, 1968 7:20 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21227 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University of Maryland Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/9/64		9. AGE (In years last birthday) 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Widconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Barry Cole		
14. MOTHER'S MAIDEN NAME Arlene Mislivecek		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		
16. SOCIAL SECURITY NO. ---		17. INFORMANT Medical Records		
18. 742 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 752 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hydrocephalus & Aqueductal Stenosis (B) DUE TO, OR AS A CONSEQUENCE OF: --- (C) DUE TO, OR AS A CONSEQUENCE OF: ---		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No.
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Oct 28 1968 to Nov 2 1968 , that (I) (we) last saw the deceased alive on Nov 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Jorge Ordonez MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JORGE ORDONEZ MD
23D. ADDRESS University of Md. Hospital BALTO.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE Nov. 5, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR G. Truman Schwab
ADDRESS 3512 Frederick Ave. Balto.				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11181 CERTIFICATE OF DEATH

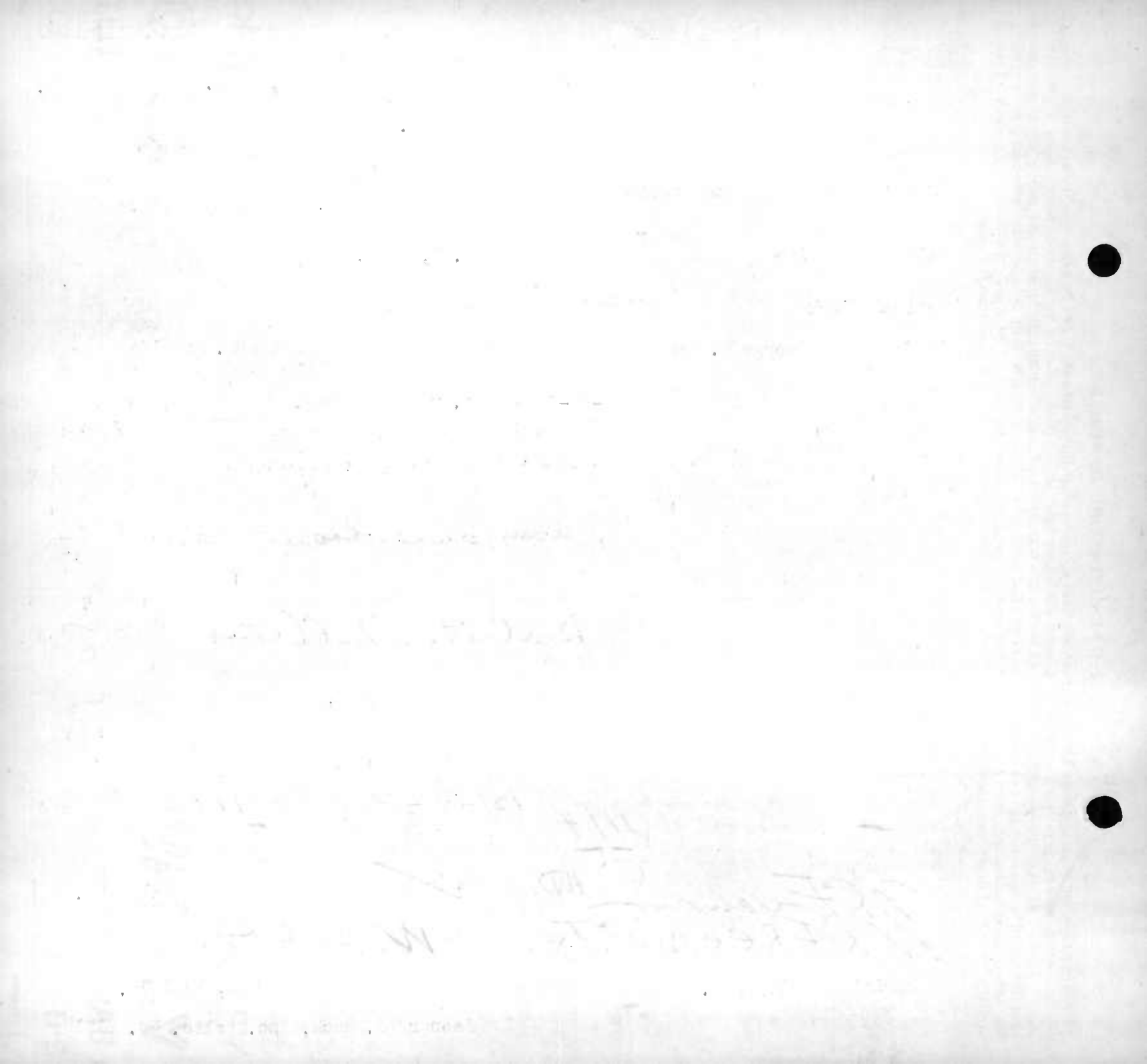
REG. NO. 68-11181

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LEWIS C. LEE		2. DATE AND HOUR OF DEATH November 6, 1968. 12:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3103 Belair Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 5-01		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3103 Belair Road		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1886	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Marine Eng.		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Lewis Scott Lee		
14. MOTHER'S MAIDEN NAME Hester Smallwood			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Marion Lee		
18. ADDRESS Same					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I Identifying. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior re-entrant Cardiac conduction disease. (B) DUE TO, OR AS A CONSEQUENCE OF: 10 yr (C) 1 wk.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 da.		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II Pneumonia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 5-5 1957 to 11-6 1968 , that (I) (we) last saw the deceased alive on 11-6 1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. DUBER MOORES				23B. DATE SIGNED 11-6-68	
23C. PHYSICIAN'S NAME (Type) J. DUBER MOORES				23D. ADDRESS 3105 Belair Rd Balto Md 21213	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11182
BIRTH NO. 68-11182		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GEORGE WILLIAM PEARL		2. DATE AND HOUR OF DEATH November 6, 1968. 5 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3018 Cresmont Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 12-06		
		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 3018 Cresmont Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1890.
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		11. BIRTHPLACE (State or foreign country) Maryland
10B. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George W. Pearl		14. MOTHER'S MAIDEN NAME Martha F. McBride		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO. 717-07-7948		17. INFORMANT Mrs. M Nancey Pearl
				ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 441.917-250.4 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Rupture of Aortic aneurysm (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis aorta (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr. 5 yr. 18 yr.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 437X II Diabetes mellitus				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/5/63 19 to 11/6 19 68 . that (I) last 11/4 1968 last saw the deceased alive on 11/4 19 68 and that in (my) own own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.				
23A. SIGNATURE J. R. Freeman M.D.		23B. DATE SIGNED 11/6/68.		
23C. PHYSICIAN'S NAME (Type) J. R. Freeman M.D.		23D. ADDRESS 11 W. 29th St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/9/68.	24C. NAME OF CEMETERY or CREMATORY Harpers Cemetery	24D. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

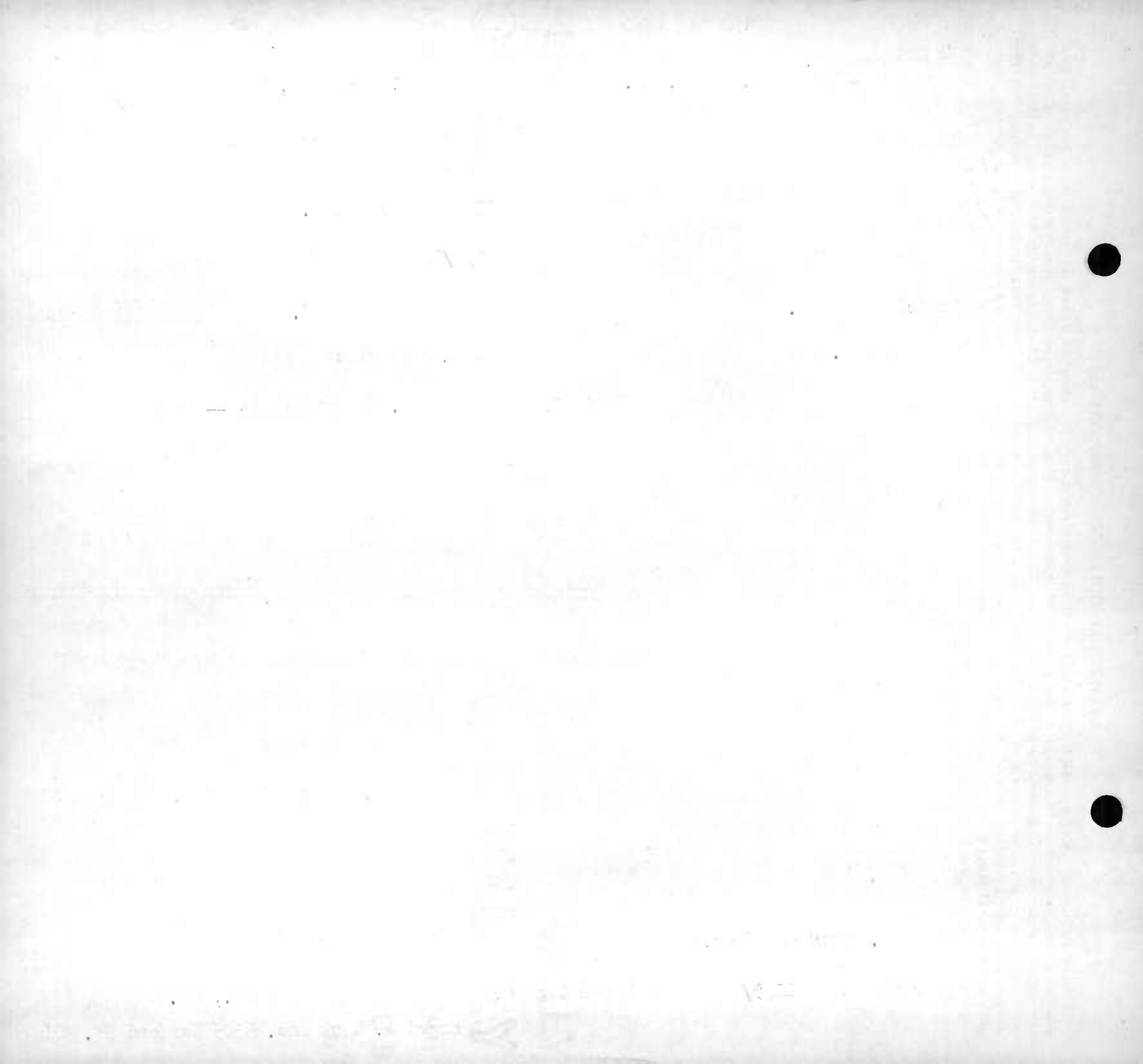
68-11183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11183

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALTER I. LEE, SR.		2. DATE AND HOUR OF DEATH November 6, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-05 C. CITY OR TOWN Baltimore (INSIDE CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3100 Woodring Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1888	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Stephen R. Lee		14. MOTHER'S MAIDEN NAME Katherine Niece			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216329637		17. INFORMANT Mrs. Mary Adele Lee-- Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute myocardial infarction I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ant rel c c disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 10 yr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/4 19 68 to 11/6 19 68 , that (I) (we) last saw the deceased alive on 11/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice Feldman				23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) Dr. Maurice Feldman		23D. ADDRESS 6610 Cran County Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.		25A. DATE RECEIVED BY HEALTH DEPT. 1500			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11184 CERTIFICATE OF DEATH

REG. NO. 68-11184

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Maria Vidi		2. DATE AND HOUR OF DEATH November 6, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5703 Winthrop Ave				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5703 Winthrop Ave	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1889	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? Italy			13. FATHER'S NAME Modesto Ferorri		
14. MOTHER'S MAIDEN NAME Maffei			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-56-5421			17. INFORMANT Mr Neal Vidi		
18. 43610 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) acute cardiac dilatation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Vascular accident arterio-sclerotic hypertension			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 ch 2 yrs 5 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3/1/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/2 1963 to 11/6 1968 , that (I) (we) last saw the deceased alive on 11/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.C. Feldman				23B. DATE SIGNED 11/7/68	
23C. PHYSICIAN'S NAME (Type) S.C. Feldman M.D.				23D. ADDRESS 1440 East Baltimore, St Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68-11185		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		68-11185	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		Anna Bertha Itoenig		11-7-68		6 ³⁰		A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 60				A. STATE Maryland					
(If not in hospital or institution, give street address or location) 3139 Northway Drive				B. COUNTY 27-05					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 3139 Northway Drive					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Nov. 21, 1905		9. AGE (In years last birthday) 62	
								11. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland	
								12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Owen F Finnegan				14. MOTHER'S MAIDEN NAME Katherine T Hopf					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-05-9642		17. INFORMANT ADDRESS Catherine Finnegan 2808 E. Baltimore St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 571.9 I CIRRHOSIS of liver				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH 3 years	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 53 to Nov. 7 19 68, that (I) (we) last saw the deceased alive on Nov. 3, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R Donald Jaydort M.D.				23B. DATE SIGNED 11-7-68					
23C. PHYSICIAN'S NAME (Type) R Donald Jaydort M.D.				23D. ADDRESS 6077 Hartford Rd					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Jaydort		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS Baltimore, Maryland			

WILLIAM
CHILDS

Circulars of 1967

Nov 21

Donald J. Ford
R.D. 19, Upton

Postmaster

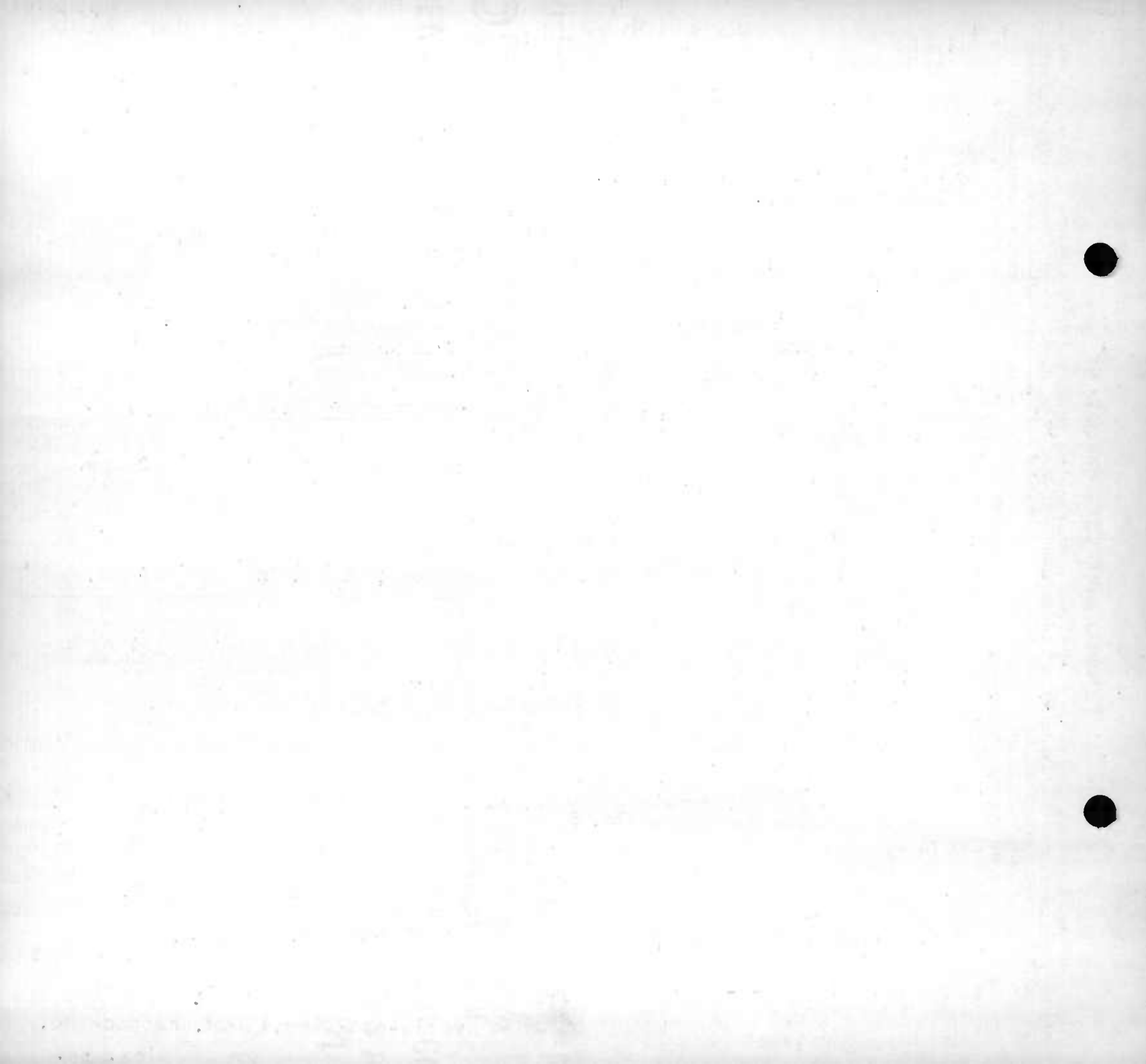
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11186 CERTIFICATE OF DEATH

REG. NO. 68-11186

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elma Gene Kloman		2. DATE AND HOUR OF DEATH Nov. 5, 1968 7: 05 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Va. B. COUNTY V-43			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Falls Church	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6456 Eppard St.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/14	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dary Jones		14. MOTHER'S MAIDEN NAME Jane Mc Clung	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. 1978 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral edema Glioma of the brain		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral edema (C) DUE TO, OR AS A CONSEQUENCE OF: Glioma of the brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk. 15 mos.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 193.0 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct. 6, 1968 to Nov. 5, 1968 , that (I) (we) last saw the deceased alive on Nov. 5, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Sutherland, MD DEGREE				23B. DATE SIGNED 11/5/68	
23C. PHYSICIAN'S NAME (Type) John C. Sutherland, MD DEGREE				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-68		24C. NAME OF CEMETERY or CREMATORY National Memorial Park	
24D. LOCATION Falls Church, Virginia		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR John C. Sutherland		25C. FUNERAL DIRECTOR Everly-Wheatley, 1500 W. Braddock Rd.	
				ADDRESS Alex. Va.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68-11187		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 66-95		68-11187	
1. NAME OF DECEASED (Type or Print) <u>SWANN, George W</u>				2. DATE AND HOUR OF DEATH <u>11/5/68</u> <u>2:40</u> A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>66-00</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Dukeland Nursing & Convalescent Home</u>				C. CITY OR TOWN <u>Capital Heights</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>812 57th Ave</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/80</u>		9. AGE (In years last birthday) <u>88</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED POLICE WASH CATHEDRAL</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH SWANN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-12-9187</u>		17. INFORMANT <u>GEO W SWANN JR.</u> ADDRESS <u>SAME AS (4E)</u>			
18. <u>342 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>BRONCHO PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PARKINSONISM</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ALZHEIMER DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>					
19. DATE OF OPERATION <u>350 X II</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>9/23</u> <u>1966</u> to <u>11/5</u> <u>1968</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>11/3</u> <u>1968</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>E C Wagoner</u>				23B. DATE SIGNED <u>5 Nov 68</u>				23C. PHYSICIAN'S NAME (Typed) <u>E C Wagoner</u>	
23D. ADDRESS <u>4200 Edmondson Ave Balto Md</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>11-8-68</u>				24C. NAME OF CEMETERY or CREMATORY <u>Rock Creek Cem</u>				24D. LOCATION (City, town, or county) (State) <u>Webster St NW. Wash. D.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>				25B. NAME OF REGISTRAR <u>W.W. Chambers Co</u>				25C. FUNERAL DIRECTOR <u>1400 Chapin St NW. Wash. D.C.</u>	

BRUNO'S BROS. & CO.
FARMERS
ILLINOIS

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68-11188 BALTIMORE CITY HEALTH DEPARTMENT

68-11188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

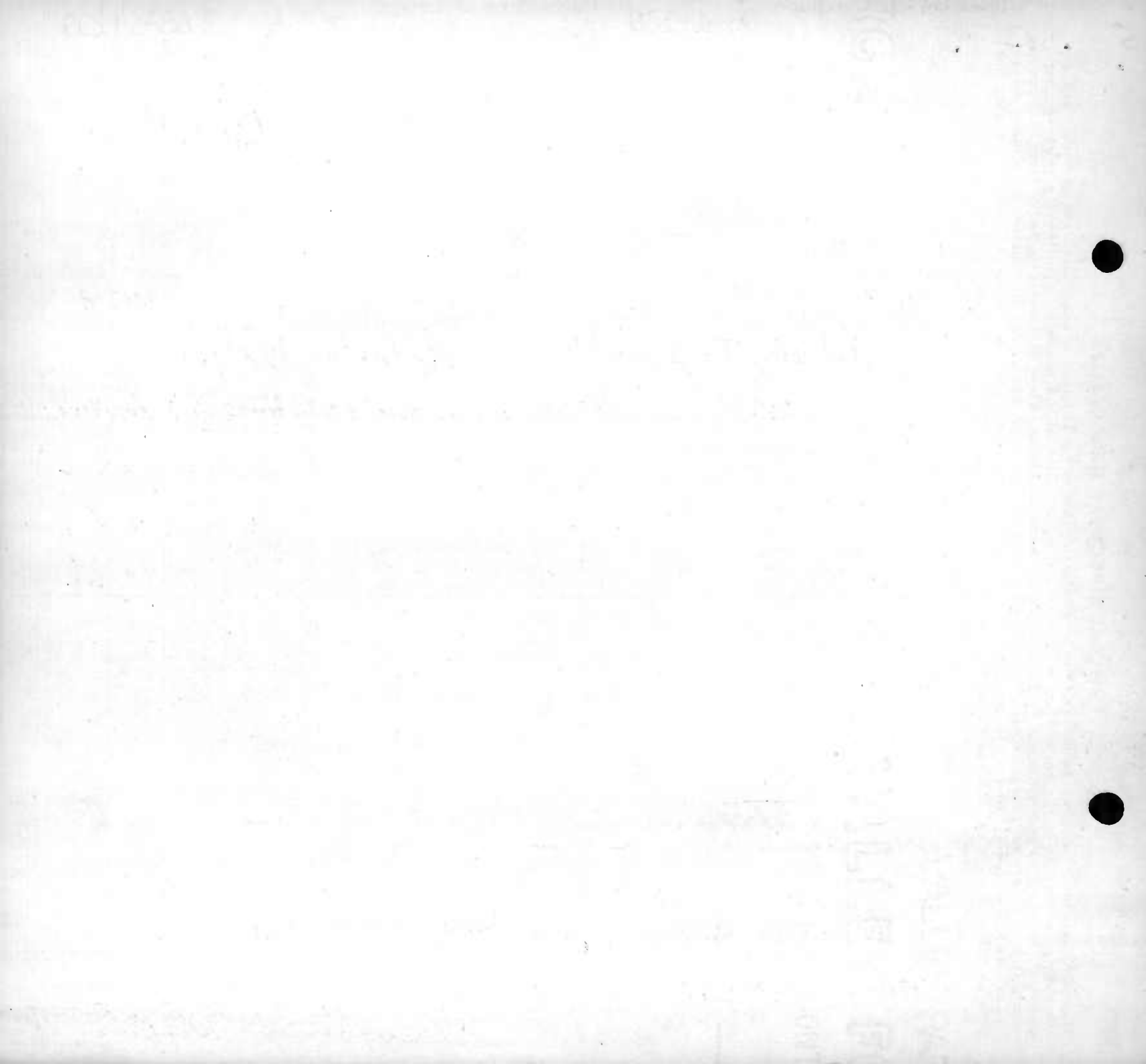
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) ARTHUR T. WALSTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 1, 1968 Hour 10:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 710 N. Linwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 1, 1968 Hour 10:10 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-10	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Mar. 21, 1886		10. AGE (In years last birthday) 82		E. STREET AND NUMBER 710 N. Linwood Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles Walston	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		14B. KIND OF BUSINESS OR INDUSTRY Seafood		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-18-5583A		18. INFORMANT Mrs. Emily Szymanski; Balt. Md.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/2/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/5/68		24C. NAME OF CEMETERY or CREMATORY Fairmount Cemetery	
24D. LOCATION (City, town, or county) (State) Fairmount; Somerset Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR James Herman	
				ADDRESS Princess Anne, Md	

W. H. R. S. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11189	
15-534 68-11189		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Adeline Schindler</u>		2. DATE AND HOUR OF DEATH <u>11/1/68</u> <u>7:05 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>38 University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll</u> <u>56-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u>		C. CITY OR TOWN <u>Sykesville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>Marvin Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/97</u>
9. AGE (In years last birthday) <u>75</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Schindler</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Walgin</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles Samorodin M.D.</u> <u>Mrs. Rose A. Schindler (Sister)</u> <u>in-law</u>		ADDRESS <u>University</u> <u>Pasadena, Md.</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u> (B) <u>Alternating ventricular tachycardia</u> 2 days DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD R/L MI</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>?</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	
20A. AUTOPSY? (Yes or No) <u>?</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> 19 <u>68</u> to <u>11/1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Evening 11/1</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Charles S. Samorodin M.D.</u>		23B. DATE SIGNED <u>11/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles S. Samorodin M.D.</u>		23D. ADDRESS <u>University Hosp Balto Md</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 5, 1968</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Pkesville, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>		25B. NAME OF REGISTRAR <u>Phyllis E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25D. ADDRESS <u>Singleton Funeral Home</u> <u>Glentburn, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11180

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHAEFFER, JOHN C		2. DATE AND HOUR OF DEATH NOVEMBER 4, 1968 4:30A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY AA C. CITY OR TOWN 21061 D. INSIDE CITY LIMITS? 52-00		E. STREET AND NUMBER 8 FERDINAND AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/02/87	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATION ATTENDANT		10B. KIND OF BUSINESS OR INDUSTRY SHELL OIL CO.		11. BIRTH PLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME (UNKNOWN) SCHAEFFER		14. MOTHER'S MAIDEN NAME MARTHA (UNKNOWN)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-7056		17. INFORMANT CATON & WILKENS AVENUES ST AGNES HOSPITAL'S RECORDS	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II		19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 19 19 68 to NOVEMBER 4 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOVEMBER 4 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Charles J. Lancelotta Jr. M.D.		23B. DATE SIGNED 11/4/68		23C. PHYSICIAN'S NAME (Type) CHARLES J. LANCELOTTA, JR. MD.	
23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES		23E. NAME OF REGISTRAR R. J. Singleton		23F. FUNERAL DIRECTOR SINGLETON FUNERAL HOME GLEN BURNIE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV. 7, 1968		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. NOV 8 1968		24F. NAME OF REGISTRAR R. J. Singleton	

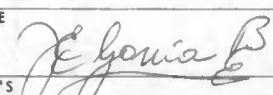
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

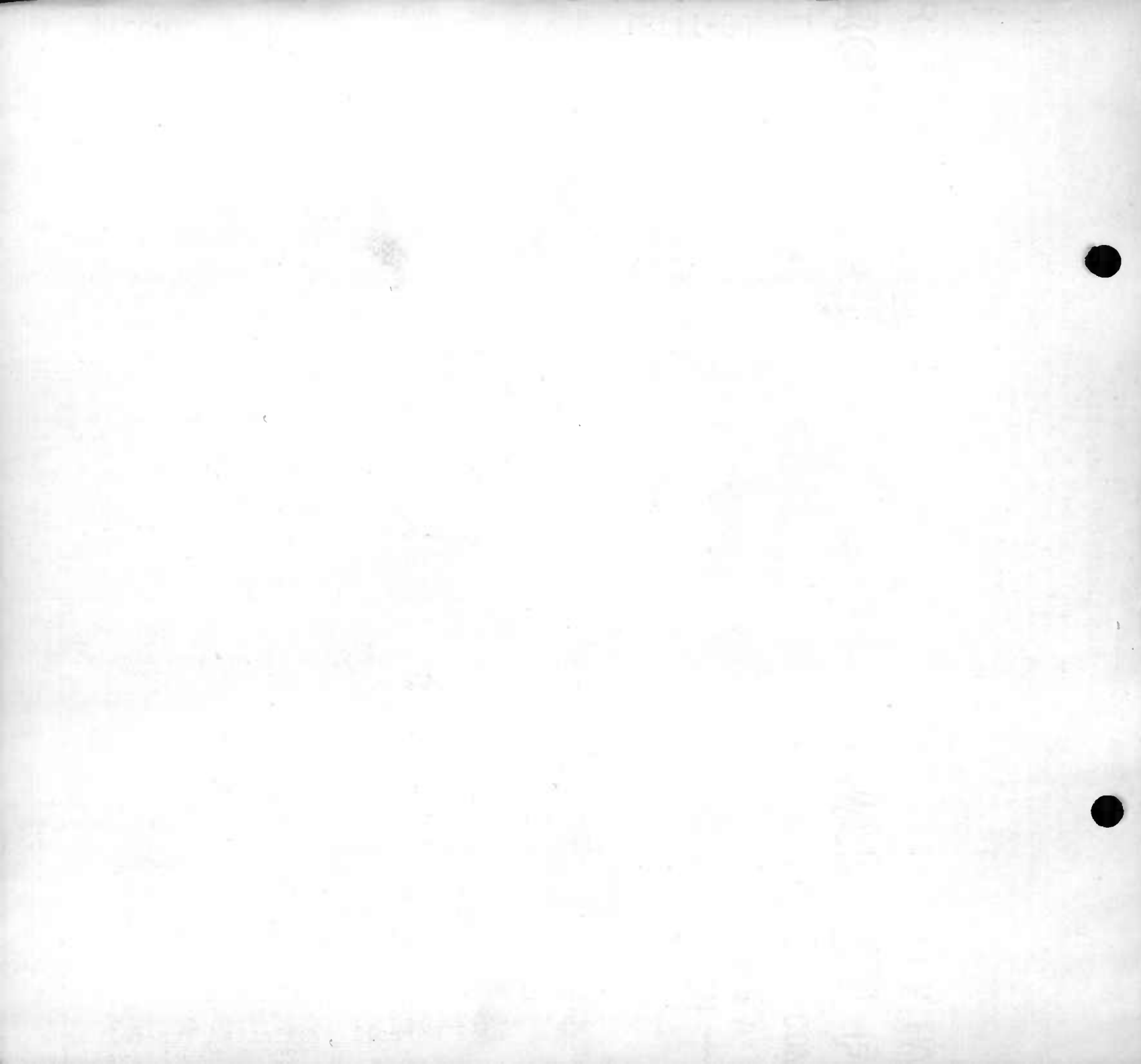
68-11191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11191

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCOTT, ARMY		2. DATE AND HOUR OF DEATH 11-7-68 9:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 20-07		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 50 N. MORLEY STREET		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 2-16-98	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Henry Scott		
14. MOTHER'S MAIDEN NAME Ida			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr Eugene Scott, Same		
18. 427.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 433.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (B) ATRIAL FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-31-1968 to 11-7-1968 , that (I) (we) lost saw the deceased olive on 11-7-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 11-7-68		
23C. PHYSICIAN'S NAME (Type) JORGE E. GARCIA			23D. ADDRESS LUTHERAN HOSPITAL OF MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY Carmichael	
24D. LOCATION (City, town, or county) Maryland		24E. DATE REC'D BY HEALTH DEPT.		25A. NAME OF REGISTRAR 1968 00021188	
25B. FUNERAL DIRECTOR I Carroll		25C. ADDRESS Halstead Funeral home		25D. ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-11192</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 68-11192 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>WILLIAM TORAN</u>			2. DATE AND HOUR OF DEATH <u>11-6-68</u> <u>5:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland Gen'l Hosp</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CITY</u> C. CITY OR TOWN <u>BALT</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>839 N. EUTAW</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-04</u>	9. AGE (in years lost birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JAMES TORAN</u>			14. MOTHER'S MAIDEN NAME <u>SARAH E. LONG</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>PT'S CHART</u>		
<div style="display: flex;"> <div style="flex: 1;"> <p>1B. <u>571.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH <u>ACUTE BRONCHITIS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>NUTRITIONAL CIRCUMSTANCES</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>AC. PANCREATITIS - RHEUM</u> <u>CHRONIC ALCOHOLISM HEART DIS.</u></p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<div style="display: flex;"> <div style="flex: 1;"> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>381.0 II</u></p> </div> <div style="flex: 1;"> <p>19A. DATE OF OPERATION <u>11/3/68</u></p> </div> <div style="flex: 1;"> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>POSS. SUBDURAL</u> <u>POSS. SUBDURAL HEMATOMA</u></p> </div> <div style="flex: 1;"> <p>20A. AUTOPSY? (Yes or No) <u>YES</u></p> </div> <div style="flex: 1;"> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u></p> </div> </div>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> <u>1968</u> to <u>11-6</u> <u>1968</u> , that (I) (we) lost saw the deceased olive on <u>11-6</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stoted above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kathryn A. Nichesell, MD</u> DEGREE				23B. DATE SIGNED <u>11-6-68</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>MD GEN' R HOSP</u> DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/9/68</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Schuyler</u>		25C. FUNERAL DIRECTOR <u>I Carroll</u> ADDRESS <u>Halstead Funeral Home</u> <u>1206 W North Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-500		68-11193		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11193	
M.E. CASE NO.				1. NAME OF DECEASED DAVID			
(Type or Print) DAWIN RAINNEY SR.				2. DATE AND HOUR OF DEATH 11-6-68 318 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				A. STATE Maryland			
(If not in hospital or institution, give street address or location)				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4603 Bowleys Lane, 21206			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 7/31/02	
White Male						9. AGE (In years lost birthday) 66	
						If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk-Western Stevedore Co				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah	
13. FATHER'S NAME RAINNEY, DAWIN				14. MOTHER'S MAIDEN NAME BLEEZE, GLADYS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-10-1809		17. INFORMANT ADDRESS Sara Carr Ranney, wife, above	
18. 167191				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Hemorrhage from R. Cerebral artery or fractured vertebral tract 1 hr			
ANTECEDENT CAUSES				(B) Carcinoma of lungs 3 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
161X II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DOA 19 to DOA 19, that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carl Bredenberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-6-68	
23C. PHYSICIAN'S NAME (Type) CARL BREDBENBERG				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Dr. E. J. ...		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane			

319-6

Handwritten for Royal
Army or Federal Service
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BoA

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BoA

Carl Rosenberg

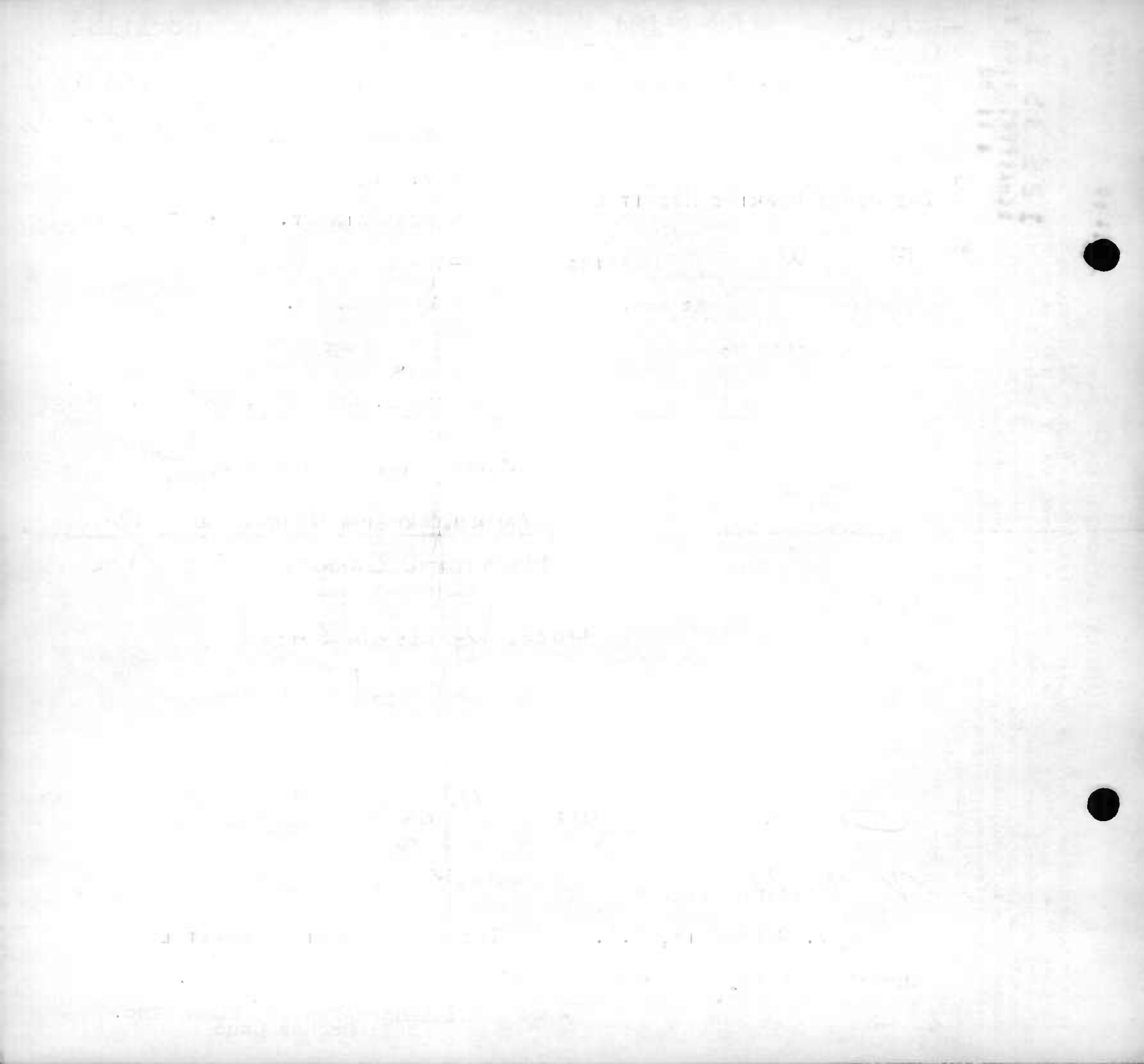
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11-0-0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-160		68-11194		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11194	
M.E. CASE NO. Anna				2. DATE AND HOUR OF DEATH 12⁵⁰ AM 11/5/68 M.			
1. NAME OF DECEASED (Type or Print) IONA SCHAEFER							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTO	
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 21 DEBONAIR CT. Apt. A-2			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 4-11-90	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles House				14. MOTHER'S MAIDEN NAME Emma Plmer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS George J. Schaefer, husband, above			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) CARDIO-PULMONARY ARREST DUE TO		-	
				(B) INTRACEREBRAL HEMORRHAGE DUE TO		13 HRS	
				(C) METASTATIC CANCER		1 YR	
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				40 LBS WT LOSS IN 6 MOS.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/4 19 68 to 11/5 19 68 , that (I) (we) last saw the deceased alive on 11/5 19 68 and that my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. Valdmanis				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/5/68	
23C. PHYSICIAN'S NAME (Type) V. VALDMANIS, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR R. E. E. J. J. J.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 13331 Pehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11195

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Johnson Arthur H.</u>		2. DATE AND HOUR OF DEATH <u>11/5/68</u> <u>11:40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore Gen. Hospital</u> <u>43</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1608 Clarkson St.</u>		F. ZIP CODE <u>21230</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-88</u>	9. AGE (In years last birthday) <u>79</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP RIGGER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>HARRY JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>212-30-4384</u>		17. INFORMANT <u>Arthur H. Johnson Jr.</u> <u>108 Burnett St.</u>			
18. <u>43019</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 MIN</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>PULMONARY INFILTRATE</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 WK - 1 Mo</u>	
		(C) <u>SUBARACHNOID HEMORRHAGE</u>		<u>9 DAYS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>330X II</u>		<u>PERNICIOUS ANEMIA</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>10/27</u> 19 <u>68</u> to <u>Nov 5</u> 19 <u>68</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>Nov 5</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert J. Greensted MD</u>		23B. DATE SIGNED <u>11/5/68</u>		23C. PHYSICIAN'S NAME (Type) <u>S. B. G. H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>11/9/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>GLEN BURNIE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert J. Greensted</u>		25C. FUNERAL DIRECTOR <u>McGilly 130 E. Fort Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

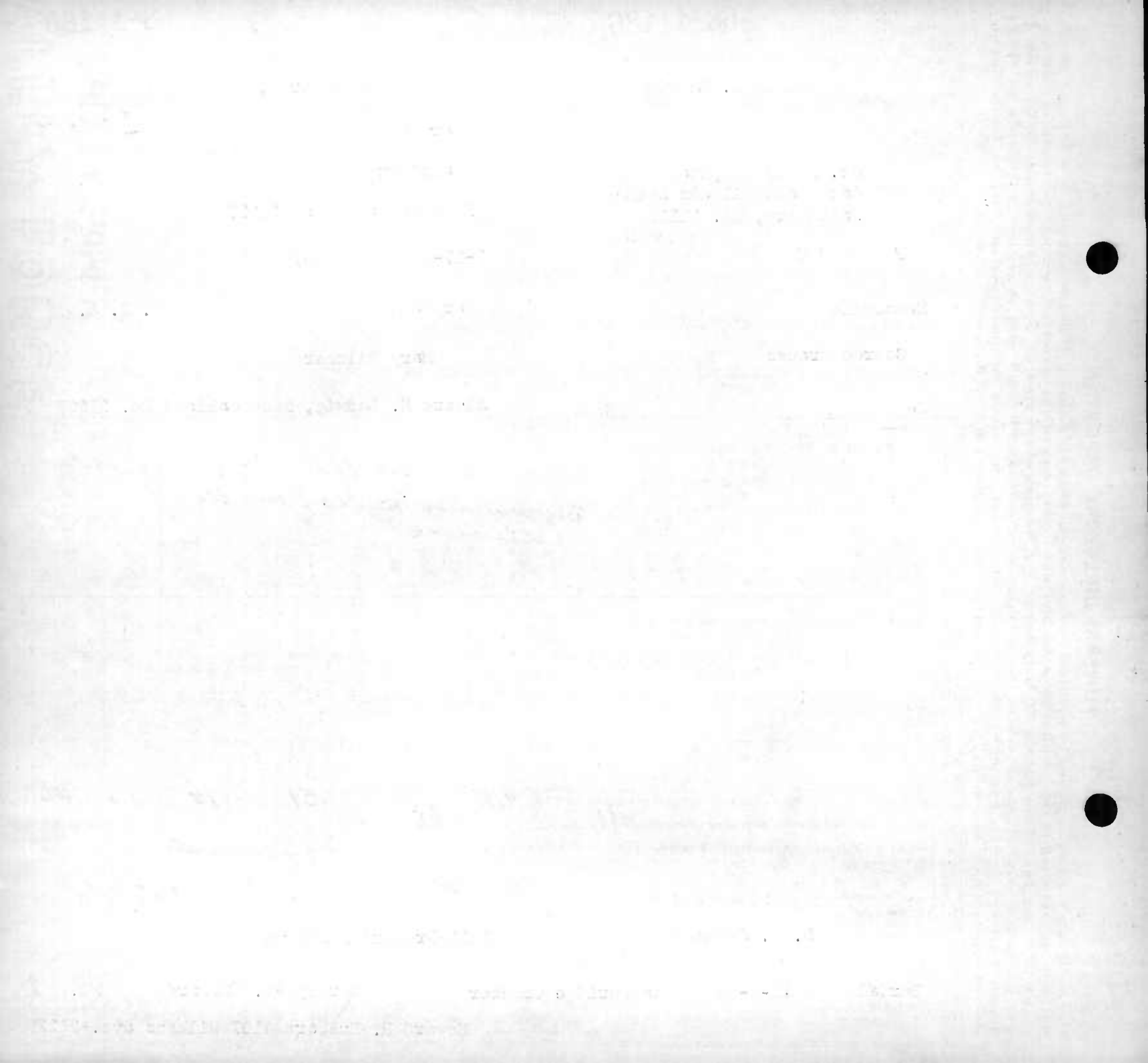
68-11196 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. X

68-11196

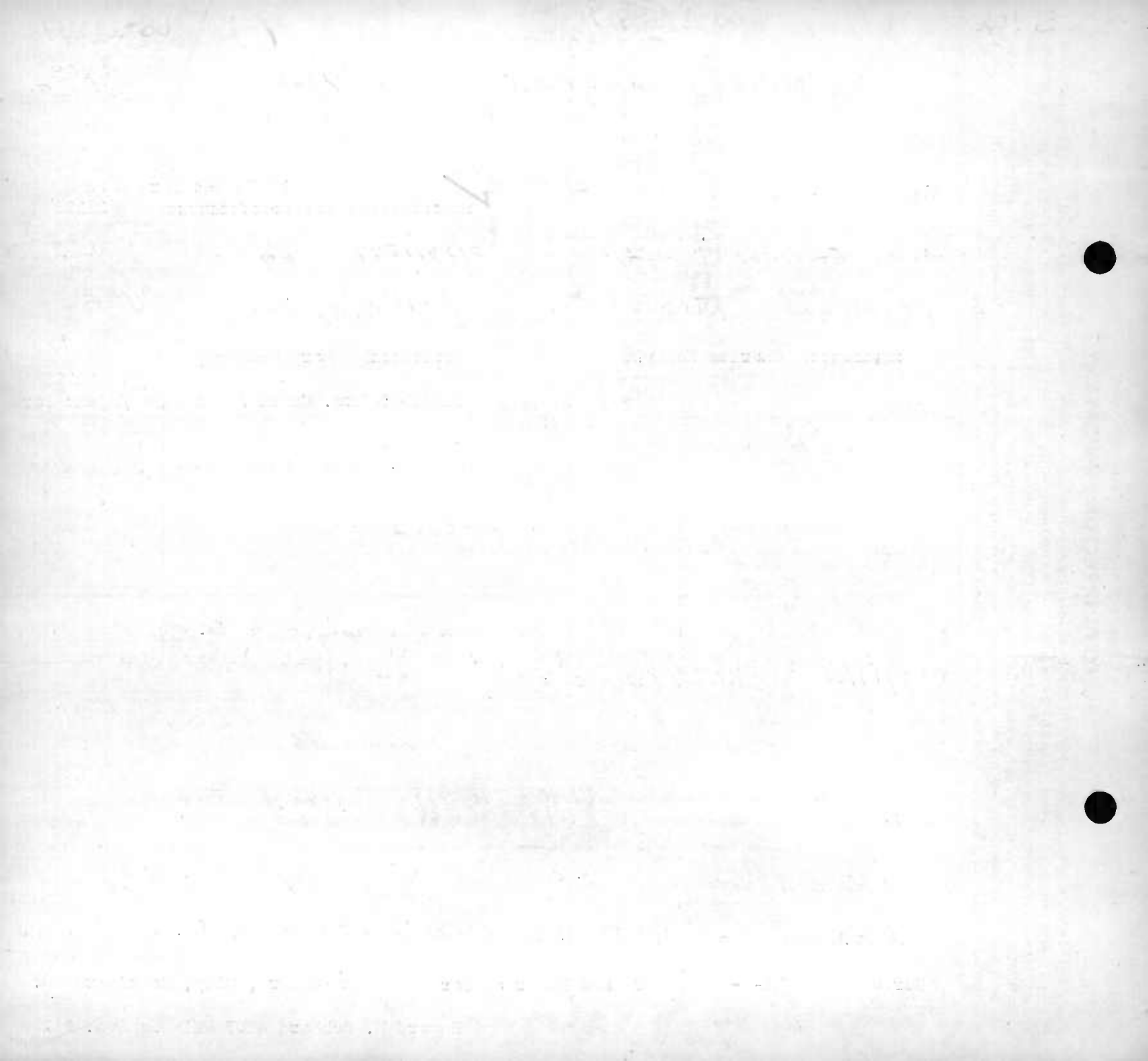
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elsie M. Ludwig		2. DATE AND HOUR OF DEATH November 6, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton and Wilkens Avenues Baltimore, Md. 21229		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5606 Oakland Road 21227			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-1901	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Krauss		14. MOTHER'S MAIDEN NAME Mary Hiltner		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Albert E. Ludwig, 5606 Oakland Rd. 21227	
18. 400.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Criminal Delusion Depressive Cardio-Vascular Lesion (B) Lesion DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 17 years			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 51 to 11/6 19 68 , that (I) (we) last saw the deceased alive on 11/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. my associates					
23A. SIGNATURE E. W. Johnson		23B. DATE SIGNED 11/7/68		23C. PHYSICIAN'S NAME (Type) E. W. Johnson	
23D. ADDRESS 3432 Frederick Avenue		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-9-68		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey Rd. Howard Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11197				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11197	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KEIMPLE, Frank Paul				2. DATE AND HOUR OF DEATH 11/7/68 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Montebello State Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Caucasian				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/29/1899 9. AGE (In years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman				10B. KIND OF BUSINESS OR INDUSTRY Transit Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown Charles Keimble			
14. MOTHER'S MAIDEN NAME Unknown Mary McClusky				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 212-16-4652				17. INFORMANT XXXXXX Mrs. Grace Jones 6138 Regent Park			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.01				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		Immediate	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) HASCD DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Pulmonary Emphysema, Severe							
19A. DATE OF OPERATION 8/29/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemic Gangrene left leg		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/1/68 to Present that (we) last saw the deceased alive on 11/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mr. Haddox Sothoron Jr. M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/7/68	
23C. PHYSICIAN'S NAME (Type) W. Haddox Sothoron Jr. M.D.				23D. ADDRESS Montebello State Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-9-68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, City, Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR R. J. [Signature]		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



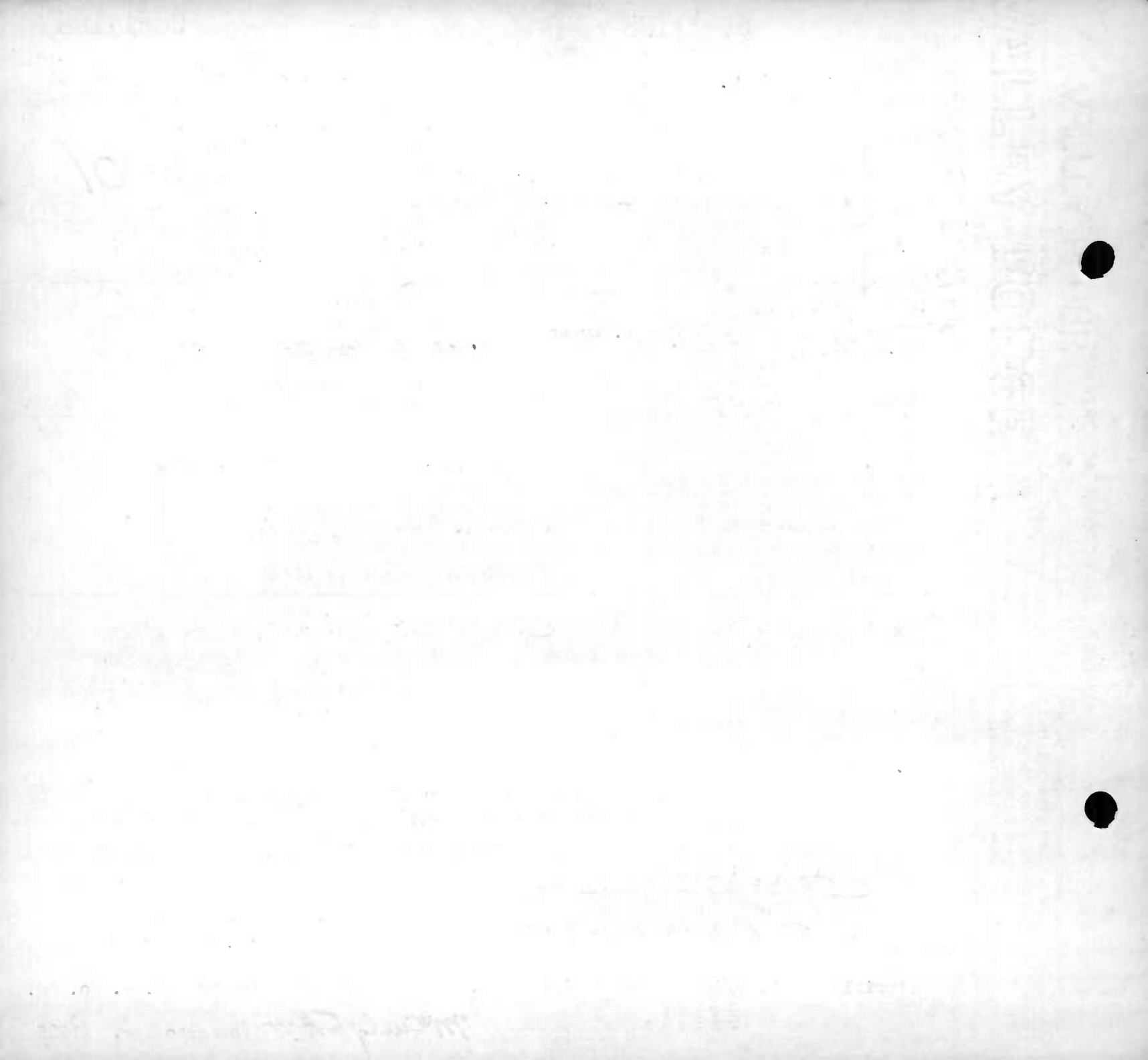
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11198 CERTIFICATE OF DEATH

REG. NO. 68-11198

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD D. LUCAS		2. DATE AND HOUR OF DEATH 11-6-68 10²⁸ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO CITY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 SOCIETY BALTIMORE GENERAL HOSP. 2001 S. HANOVER ST. #21230				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 520 S. HANOVER ST					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-26	9. AGE (In years last birthday) 42
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Nathan R. Lucas				14. MOTHER'S MAIDEN NAME Cora Boswell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. ?		17. INFORMANT Walter Kelly Friend 520 S. Hanover St. Balto	
MEDICAL CERTIFICATION 18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC ALCOHOLISM CHRONIC GASTRITIS 581.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cirrhosis - liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11 PM 11-5-68 to 11-6-68 that (I) (we) last saw the deceased alive on 10:30 AM 11-6-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. G. Baymann M.D.				23B. DATE SIGNED 11-7-68	
23C. PHYSICIAN'S NAME (Type) C. G. BAYMANN M.D.				23D. ADDRESS 2001 S. Hanover St Baltimore, Md 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Highway A. A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Seaborn		25C. FUNERAL DIRECTOR McCully T. H. 237 Patapsco Ave. 21225	



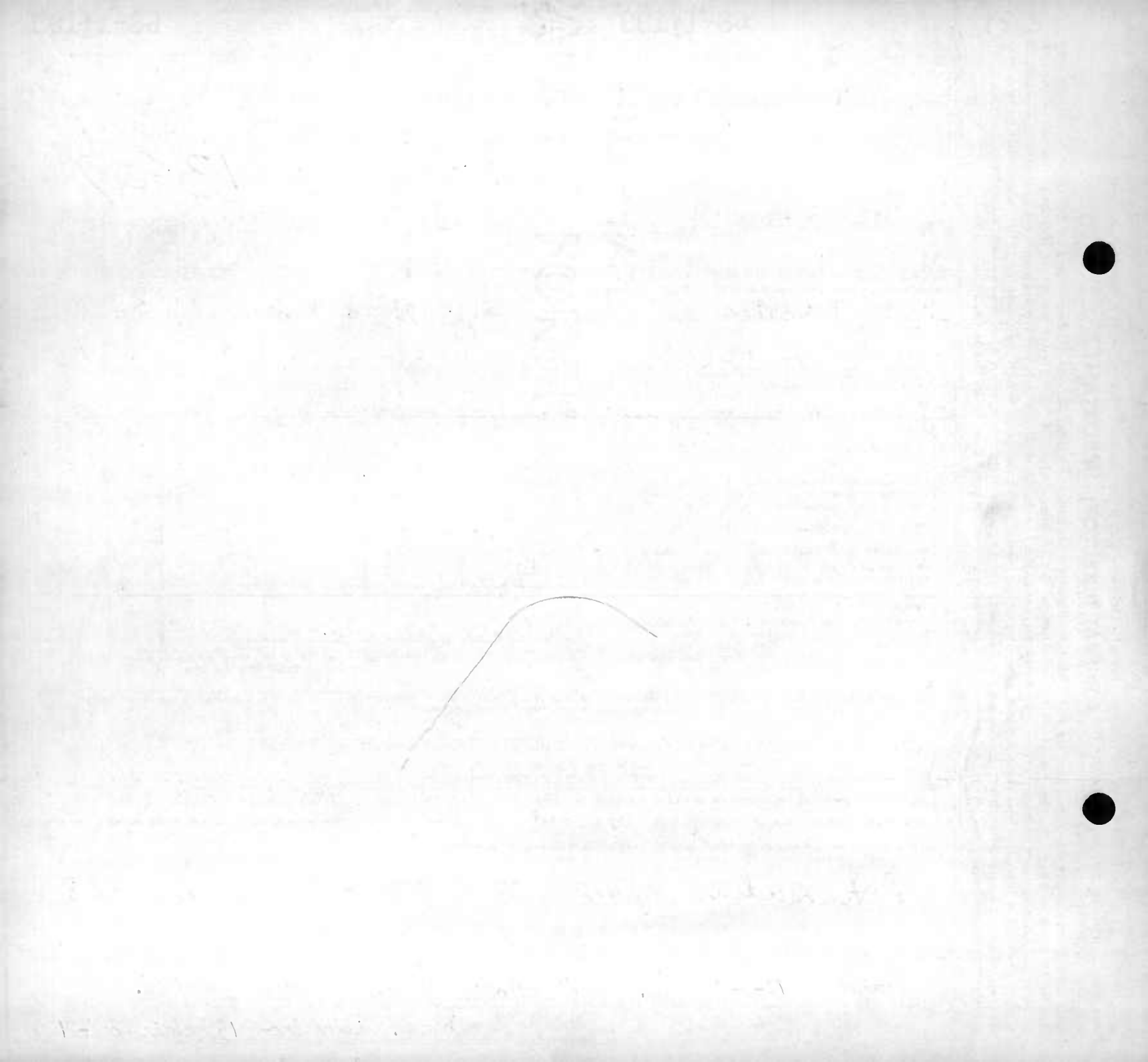
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11199 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11199

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. EARLE W PEREGOV		2. DATE AND HOUR OF DEATH Nov. 3rd 1968 3⁴⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Keswick		C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FULL NAME OF HOSPITAL OR INSTITUTION 71 Keswick Home + Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 700 W 40th ST.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1916	9. AGE (In years last birthday) 52 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALTO. TRANSIT CO.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hampstead Maryland	
13. FATHER'S NAME CLARENCE PEREGOV		14. MOTHER'S MAIDEN NAME GRACE E RHOTER		12. CITIZEN OF WHAT COUNTRY? U. S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W WART		16. SOCIAL SECURITY NO. 215-08-0284		17. INFORMANT G. S. McFAUL, R.N. ADDRESS 700 W. 40th ST.	
1. 472531		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GI bleeding & shock & aspiration		1 wk.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		(B) Stomach ulcer DUE TO, OR AS A CONSEQUENCE OF:			
(C) ASAD					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II Cerebral atherosclerosis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEB. 12, 1968 to Nov. 3, 1968 , that (I) (we) last saw the deceased alive on Nov. 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. H. Miller, Jr.		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-4-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-68		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Methodist Cemetery	
24D. LOCATION (City, town, or county) (State) Mt. Carmel Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Road-21206	



R-100

68-11200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11200

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE CRAWFORD RUBY

2. DATE AND HOUR OF DEATH

11/4/68

11:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)44 UNION MEMORIAL HOSPITAL
33RD CALVERT STS4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD.

U.S.A.

C. CITY OR TOWN

BART MD

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3517 ELMER AVE

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2/8/18

9. AGE (In years
last birthday)

50

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Ruby

14. MOTHER'S MAIDEN NAME

Grace Gorty

15. Was Deceased Ever in U. S. Armed Forces?

Yes ☒ No ☐ (If yes, give war or dates of service)

WW2

16. SOCIAL SECURITY NO.

217-09-9832

17. INFORMANT

Constance Ruby

ADDRESS

Same

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute myocardial infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary arteriosclerosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/4 1968 to 11/4 1968,
that (I) (we) last saw the deceased alive on 11/4 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald M. Legum MD.

DEGREE

Attending ☐Med. ☐Staff ☒

23B. DATE SIGNED

11/4/68

23C. PHYSICIAN'S
NAME (Type)

RONALD M. LEGUM, MD.

DEGREE

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/6/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE MD

25A. DATE REC'D BY HEALTH DEPT.

NOV 8 1968

25B. NAME OF REGISTRAR

R. S. Legum

25C. FUNERAL DIRECTOR

R. S. Legum 6067 Hayford Rd

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

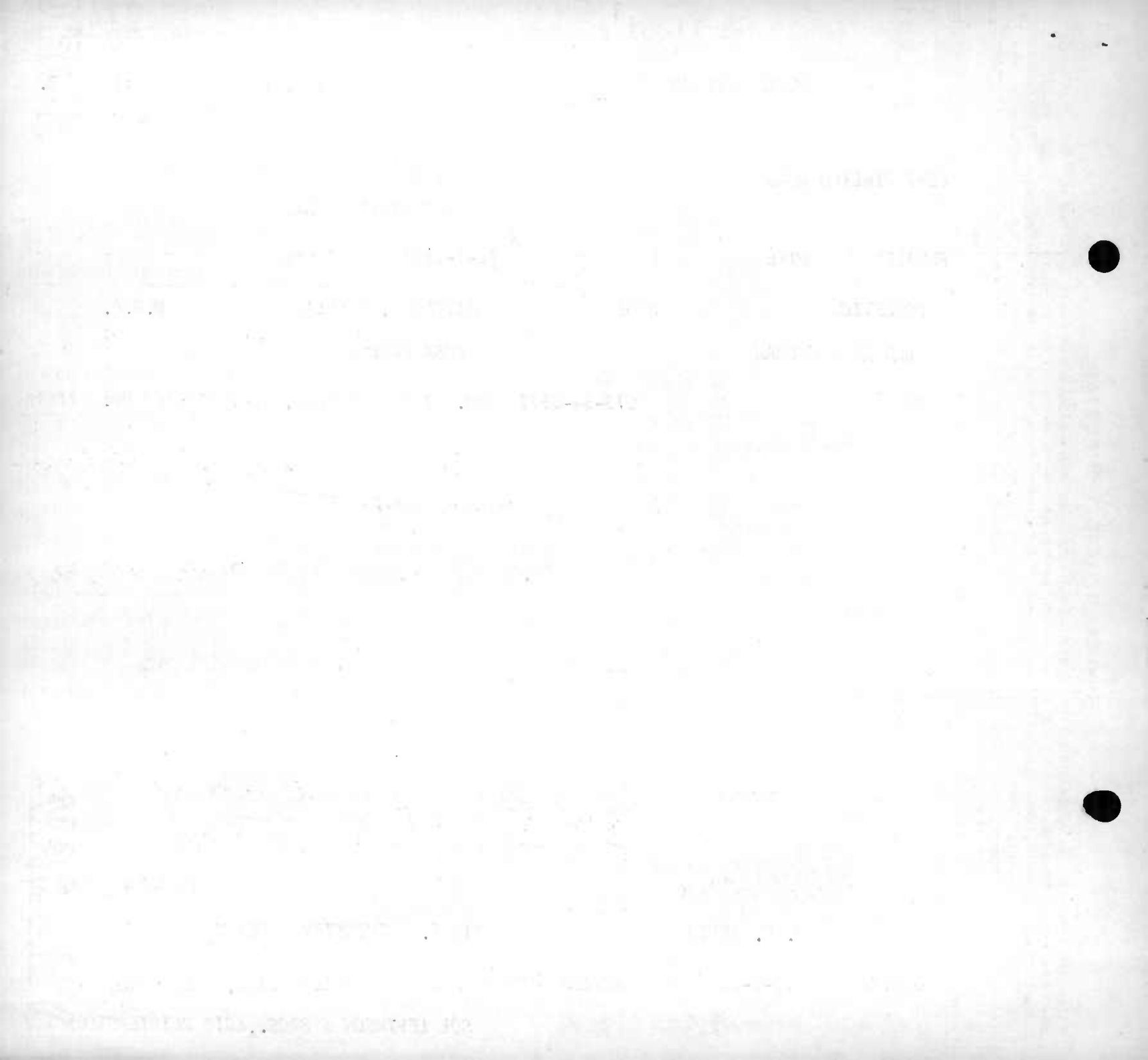
68-11201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11201

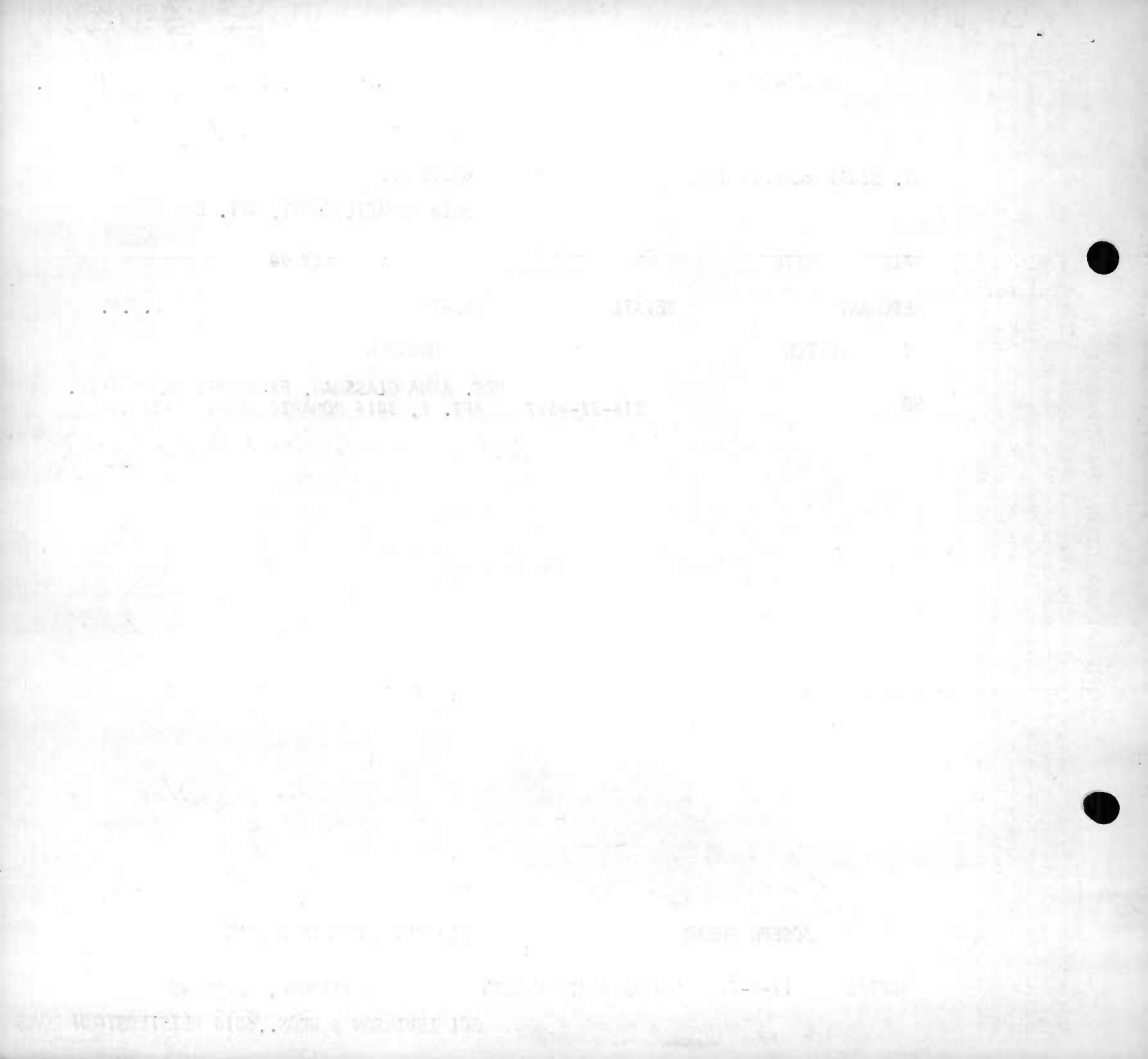
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		TOBIE ROSEMAN		NOVEMBER 5, 1968 12:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 6247 PIMLICO ROAD		A. STATE MARYLAND		B. COUNTY 27-15	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6247 PIMLICO ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1899	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LEHMAN R OSEMAN		14. MOTHER'S MAIDEN NAME ROSA ROSEMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-54-2571		17. INFORMANT MRS. MIRIAM HARFELD, 6247 PIMLICO RD. #21209	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 431.01		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis & Hypertension		20 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 18 to Oct 5, 1968 that (I) (we) last saw the deceased alive on Oct 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 12:15 PM					
23A. SIGNATURE M. B. LEVIN		23B. DATE SIGNED OCT 5, 1968		23C. PHYSICIAN'S NAME (Type) M. B. LEVIN	
23D. ADDRESS 218 E. UNIVERSITY PARKWAY		23E. ATTENDING PHYSICIAN Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-7-68		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL	
24D. LOCATION (City, town, or county) (State) BOWLEYS LANE, BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. NOV 8 1968		24F. NAME OF REGISTRAR Sol Levinson	
24G. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.		68-11202	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BENJAMIN DORTCH		NOVEMBER 6, 1968 1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MT. SINAI NURSING HOME 90				A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3014 ROMARIC COURT, APT. E			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? DORTCH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-32-4587		17. INFORMANT MRS. ANNA GLASSMAN, FALLSTAFF MANOR APTS. APT. E, 3014 ROMARIC COURT #21209		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.3 I arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH arteriosclerotic Heart Disease 20 Yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.0 II Bunchopneumonia						2 WK	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 1963 to 11/6/68 and that (H) (we) last saw the deceased alive on 11/4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Shear				23B. DATE SIGNED 11/6/68			
23C. PHYSICIAN'S NAME (Type) JOSEPH SHEAR				23D. ADDRESS 6715 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-7-68		24C. NAME of CEMETERY or CREMATORY AHAVAS CHAIM VEREIN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

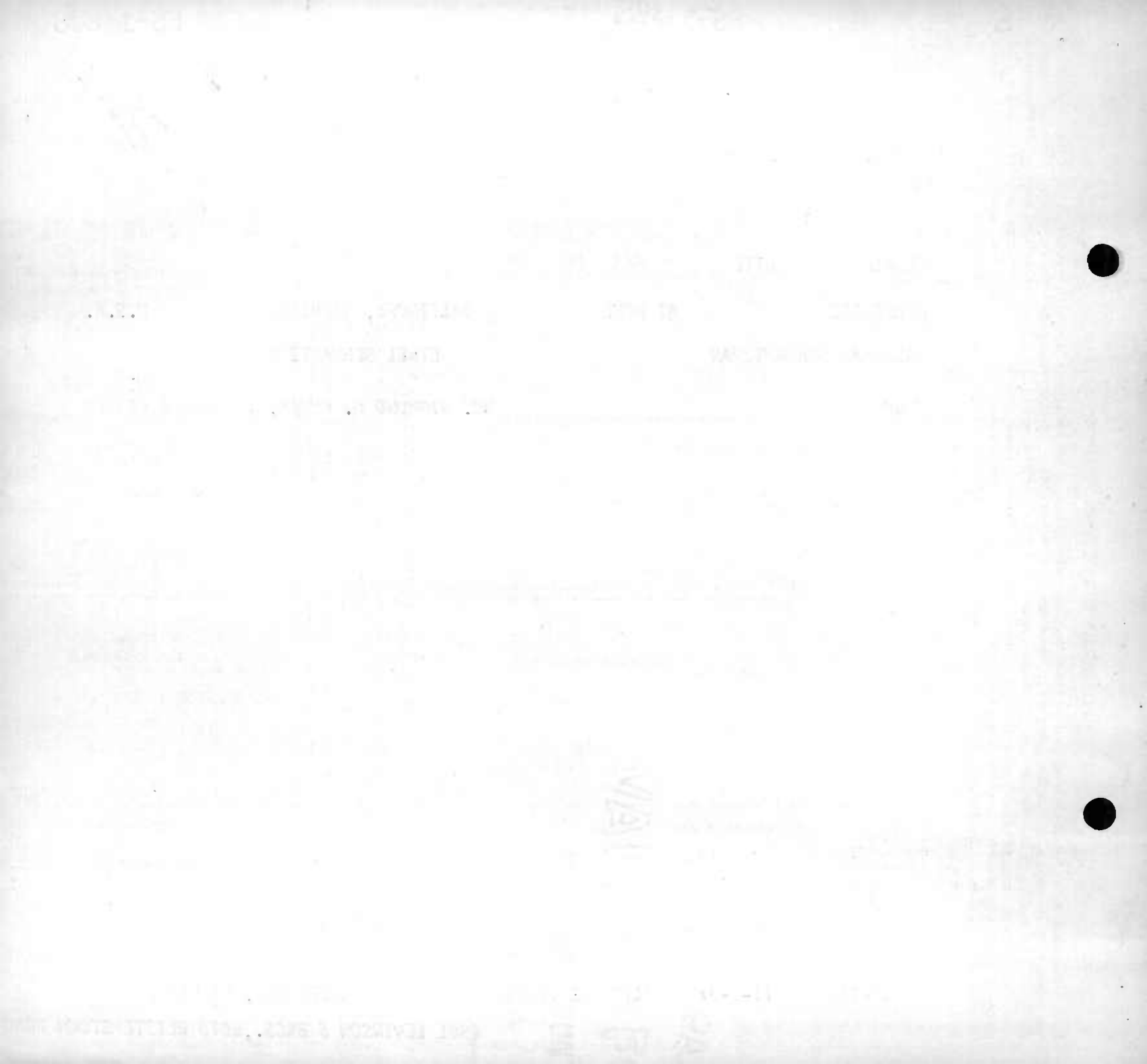
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11203

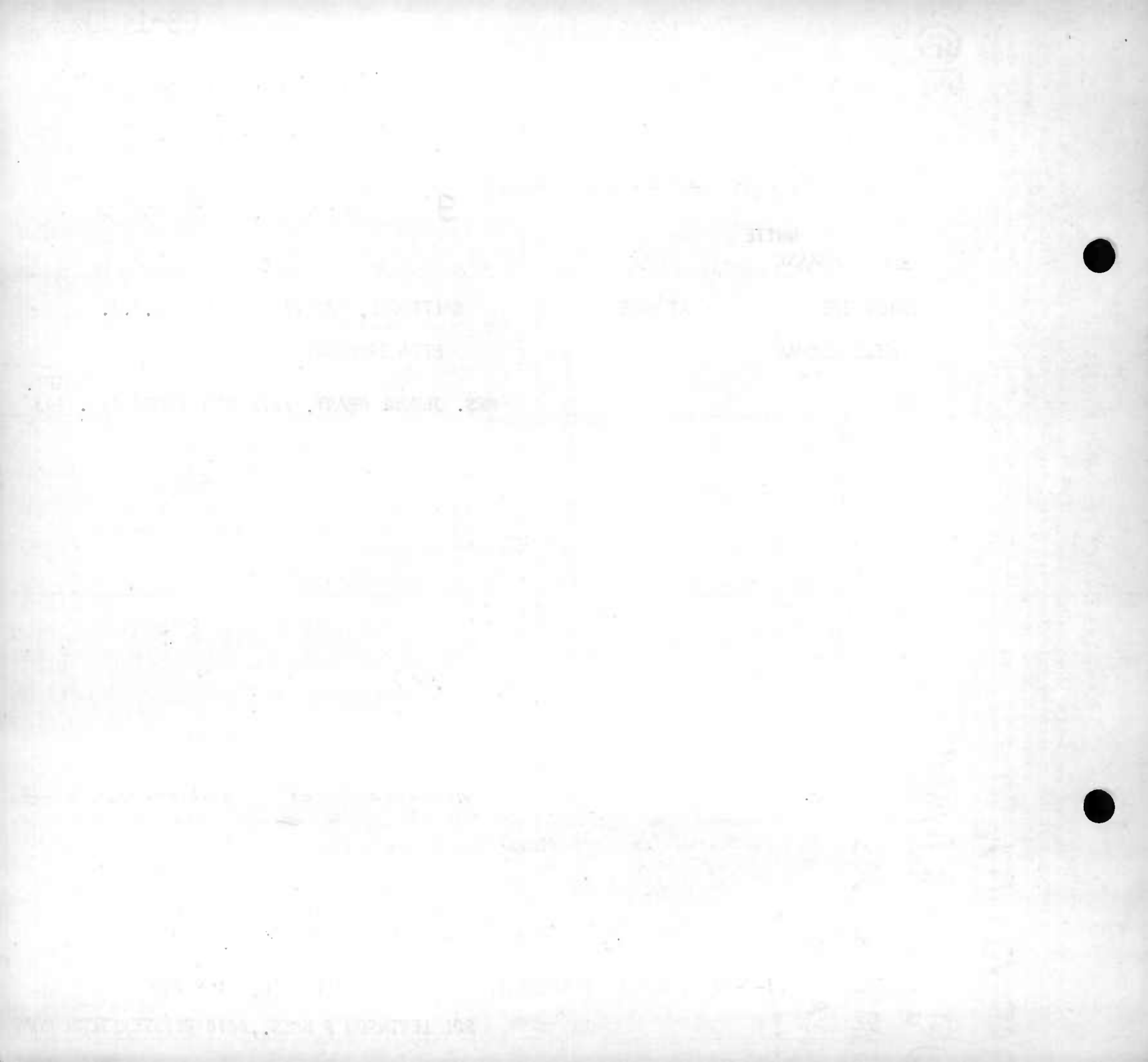
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Beatrice S. Hyman</u>		2. DATE AND HOUR OF DEATH <u>Nov. 4, 1968</u> <u>1:40</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>12-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>116 W. University Pkwy</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/95</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>ABRAHAM SCHWARTZMAN</u>			14. MOTHER'S MAIDEN NAME <u>ETHEL SCHWARTZMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>MR. SIGMUND M. HYMAN, 1 CHARLES CENTER</u>			ADDRESS <u>SUITE 900</u>		
18. <u>450 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>465 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Uremia</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Embolus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>7 months</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/5/68</u> 19 to <u>Nov 4</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barton A. Cohen</u>				23B. DATE SIGNED <u>Nov. 4, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Barton Cohen</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Nov 6 1968</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

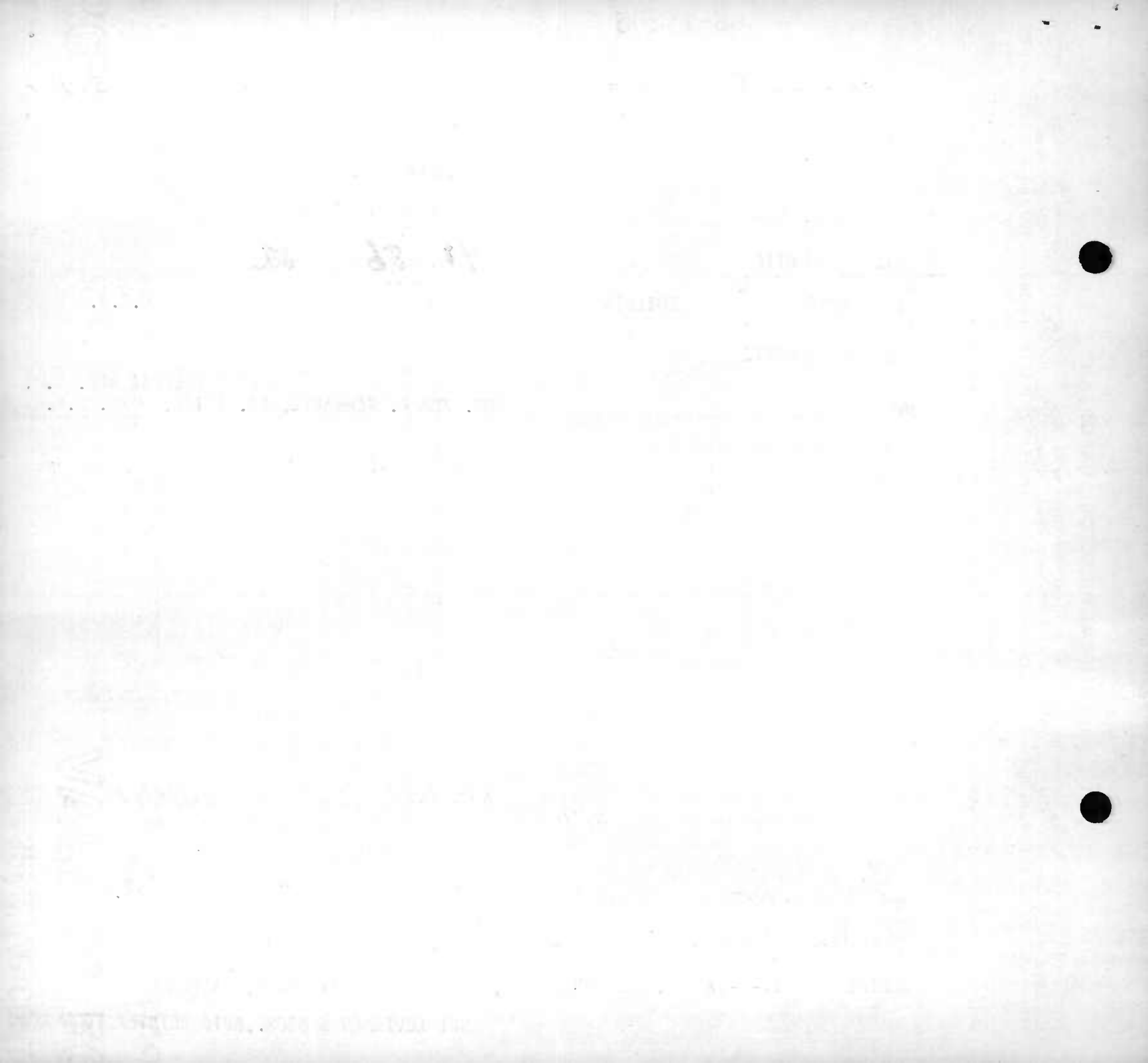
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11204
BIRTH NO. 360		68-11204 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) MAYME KADER		2. DATE AND HOUR OF DEATH 4 November 1968 7:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 7313 Park Heights Avenue		
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/90	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MOSES BERMAN		
14. MOTHER'S MAIDEN NAME ETTA ZAGORSKY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. JEROME GRANT, 7313 PARK HIGHTS AVE. 103		
18. 434.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Embolus DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from 3 November 1968 to 4 November 1968 , that (we) last saw the deceased alive on 4 November 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.				
23A. SIGNATURE Morris Ostroff M.D.		23B. DATE SIGNED 4 Nov 1968		23C. PHYSICIAN'S NAME (Type) Morris Ostroff M.D.
23D. ADDRESS Sinai Hospital of Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 11-6-68		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

632		68-11205		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11205	
1. NAME OF DECEASED (Type or Print) Abraham Schwartz				2. DATE AND HOUR OF DEATH Nov. 5, 1968 5:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sina Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 27-20			
5. SEX MALE 6. RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/14/1886 9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10B. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (State or foreign country) RUMANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SCHWARTZ				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. IRA R. SCHWARTZ, APT. 1016E, WASH. D.C. ADDRESS 4201 CATHEDRAL AVE. N.W.			
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/7/68 19 to 11/5/68 19, that (I) (we) last saw the deceased alive on 11/5/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barton Cohen M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/5/68	
23C. PHYSICIAN'S NAME (Type) Barton Cohen M.D. DEGREE				23D. ADDRESS Sina Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-6-68		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN,		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON, & BROS., 6010 REISTERSTOWN ROAD			



68-11206

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11206

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Dudley, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> 11 2 1968 12:10 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 1968 12:20 PM	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 3-00		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX M	7. RACE W	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Feb 2, 1918		10. AGE (In years lost birthday) 50 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Feb 42 to Oct 45		17. SOCIAL SECURITY NO. 216-16-5153	
18. INFORMANT Indian Head, Maryland		15. MOTHER'S MAIDEN NAME Lillian Biar	
19. 412.4 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/3/1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 7, 1968	
24C. NAME OF CEMETERY or CREMATORY St. John's		24D. LOCATION (City, town, or county) (State) Pomonkey, Charles Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Sweeney	
25C. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata,		ADDRESS Maryland	

VALLEY FORD

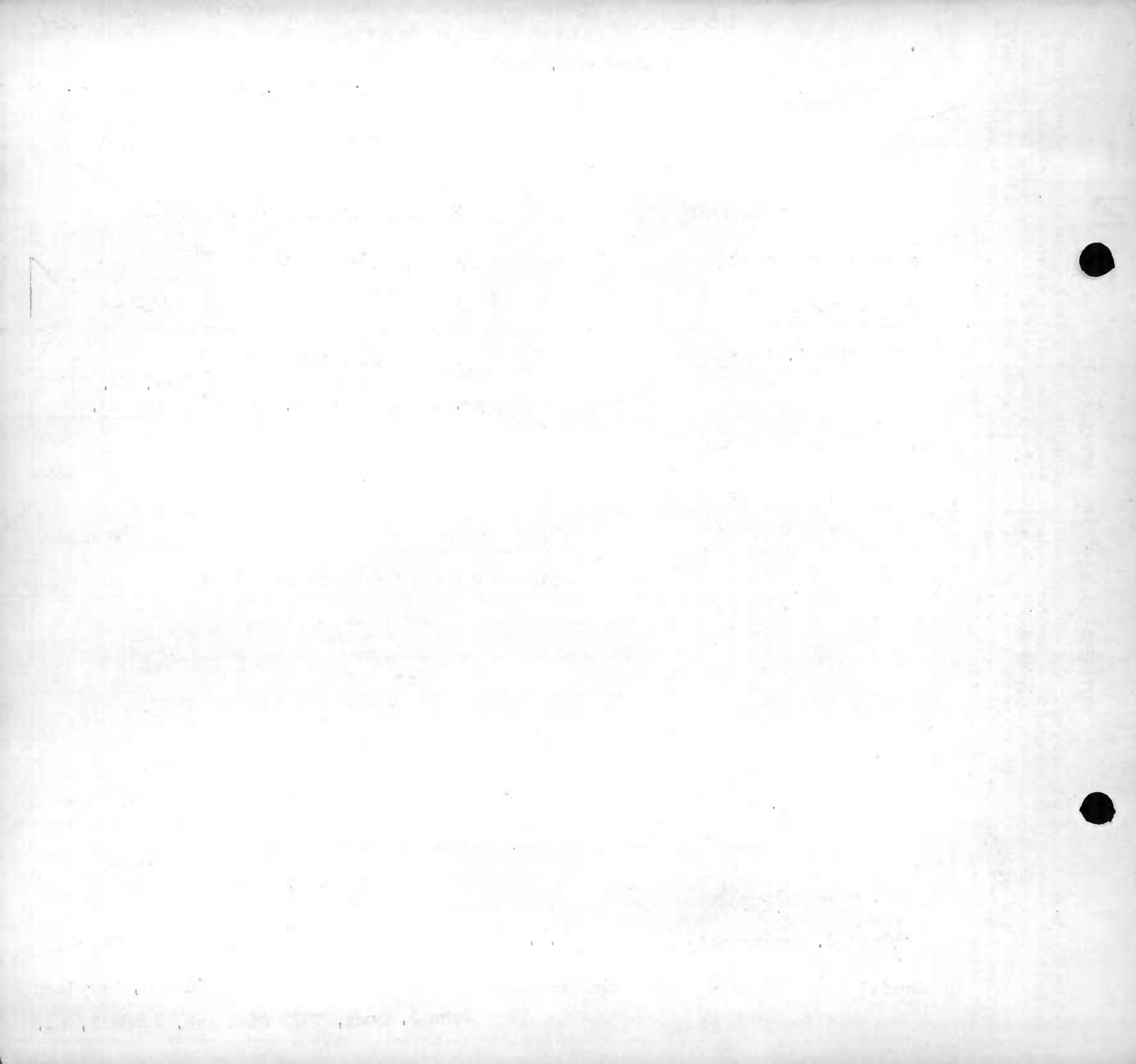
VALLEY FORD

James R. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11207 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11207
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CATHERINE NERF		2. DATE AND HOUR OF DEATH 11/5/68 5:40 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8107 BULLNECK RD.		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-14	9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick L. HESS		
14. MOTHER'S MAIDEN NAME LENA Schorr		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None		17. INFORMANT (Husband) Mr. Eugene Nerf Sr. ADDRESS Dundalk, Md. 21222		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 189.041 230.9 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 180X II		CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY CONGESTION DUE TO, OR AS A CONSEQUENCE OF: (B) METASTATIC PULMONARY LESIONS DUE TO, OR AS A CONSEQUENCE OF: (C) HYPERNEPHROMA OF LEFT KIDNEY DIABETES MELLITUS		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from OCT 20 19 68 to Nov 5 19 68 , that (I) (we) last saw the deceased alive on Nov 5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Robert J. Rosensteel		23B. DATE SIGNED 11/5/68		23C. PHYSICIAN'S NAME (Type) Robert J. Rosensteel
23D. ADDRESS M.D. South Baltimore Gen Hosp		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11/8/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

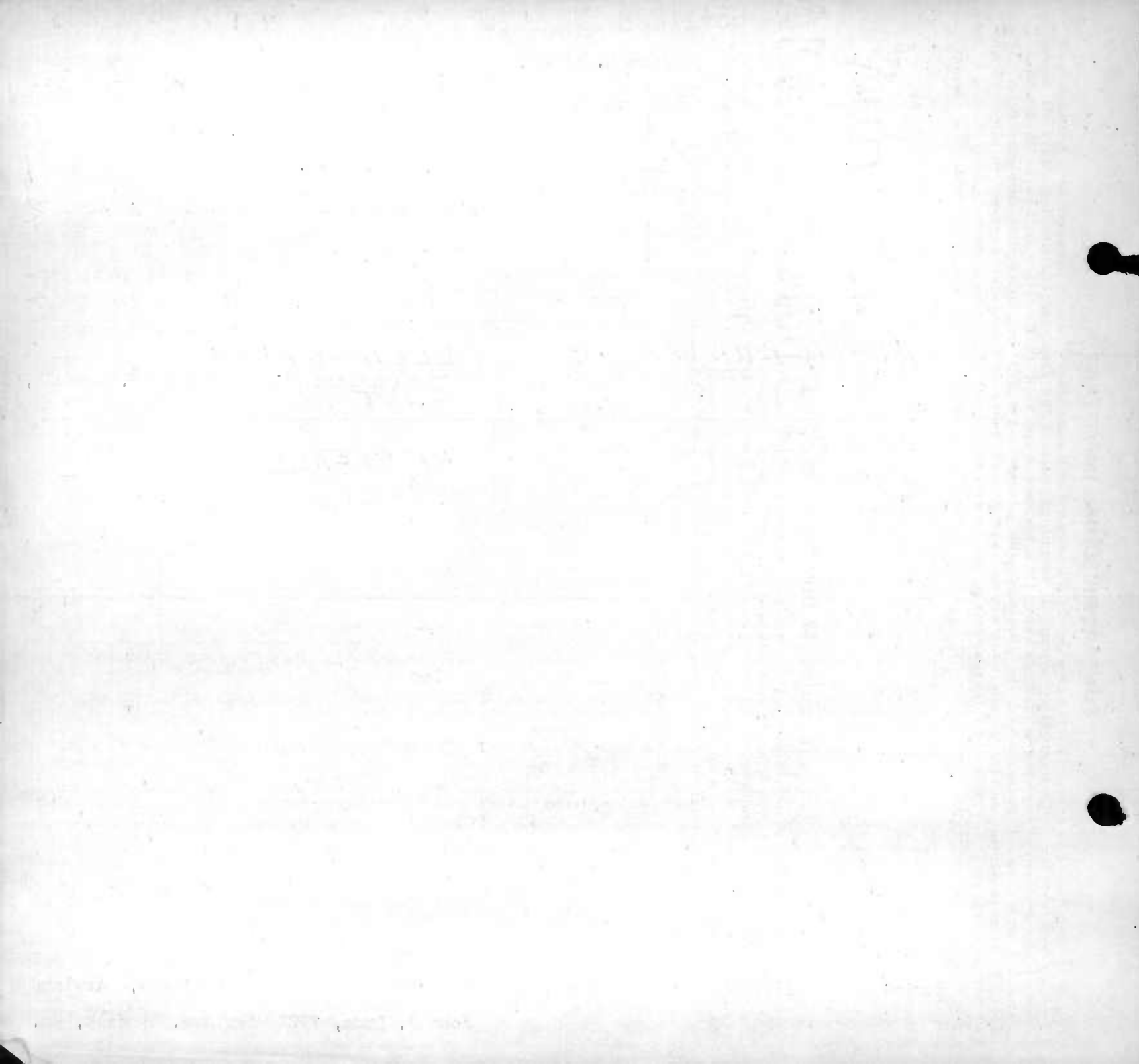
68-11208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11208

BIRTH NO.		1. NAME OF DECEASED (Type or Print) KIESLING		June E. Kiesling		2. DATE AND HOUR OF DEATH NOVEMBER 6, 4:35am	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital				A. STATE MARYLAND B. COUNTY U.S.A			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSP.				C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1803 DUNMORE ROAD 21222			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/31		9. AGE (In years lost birthday) 37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ADAM KUNDRA TIC				14. MOTHER'S MAIDEN NAME ELLA FRICK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26 2908		17. INFORMANT (Husband) 1803 Dunmore Rd. Dundalk, Md. GUST AV KIESLING Jr			
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CA BREAST C ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GENERALIZED METASTATIC				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170X II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from Oct 14 19 68 to Nov 6 19 68 . that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Vana sin				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Nov. 6 '68	
23C. PHYSICIAN'S NAME (Type) C. VANASIN				23D. ADDRESS FRANKLIN SQUARE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11209	
1. NAME OF DECEASED (Type or Print) Snyder, Rose M.		2. DATE AND HOUR OF DEATH 11-5-68 11:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21224			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6120 Bessimer Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-32	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph BROCATO		14. MOTHER'S MAIDEN NAME Lucy Cesenaro	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-28-5645		17. INFORMANT ADDRESS North Chas. Gen. Hosp. chart	
18. 230.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-4-1968 to 11-5-1968 , that (I) (we) last saw the deceased alive on 11-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel A. Gongon M.D.		23B. DATE SIGNED 11-5-68		23C. PHYSICIAN'S NAME (Type) MANUEL A. GONGON M.D.	
23D. ADDRESS N. CHARLES GEN. HOSP		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) NORTH CHARLES, BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.	

Wm. A. ...
Director ...

MANUEL A. GONZALEZ AND N. CHARLES GONZALEZ
X
11-2-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11210 CERTIFICATE OF DEATH

REG. NO.

68-11210

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

John M. Robinson Jr.

2. DATE AND HOUR OF DEATH

11-5-68 9:06 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE **Md.** B. COUNTY **Baltimore**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**BALT. CITY HOSP.
4940 EASTERN AVE.**

6943 BELCLARE ROAD

53-00

C. CITY OR TOWN **Dundalk**

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

6943 BELCLARE ROAD

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7-16-15

9. AGE (In years last birthday)

53

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John M. Robinson Sr.

14. MOTHER'S MAIDEN NAME

Catherine Beck

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-09-1379

17. INFORMANT (Wife)

Mrs. Mary E. Robinson, 6943 Belclare Rd.

Dundalk, MD 21222

18. **410.91**

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC PULM

ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION

(C)

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from **11-5-68** to **11-5-68**, that (1) (we) last saw the deceased alive on **11-5-68** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bruce M. Bucher MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-5-68

23C. PHYSICIAN'S NAME (Type)

BRUCE M. BUCHER MD

23D. ADDRESS

Balt. City Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/9/68

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Dorsey, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 8 1968

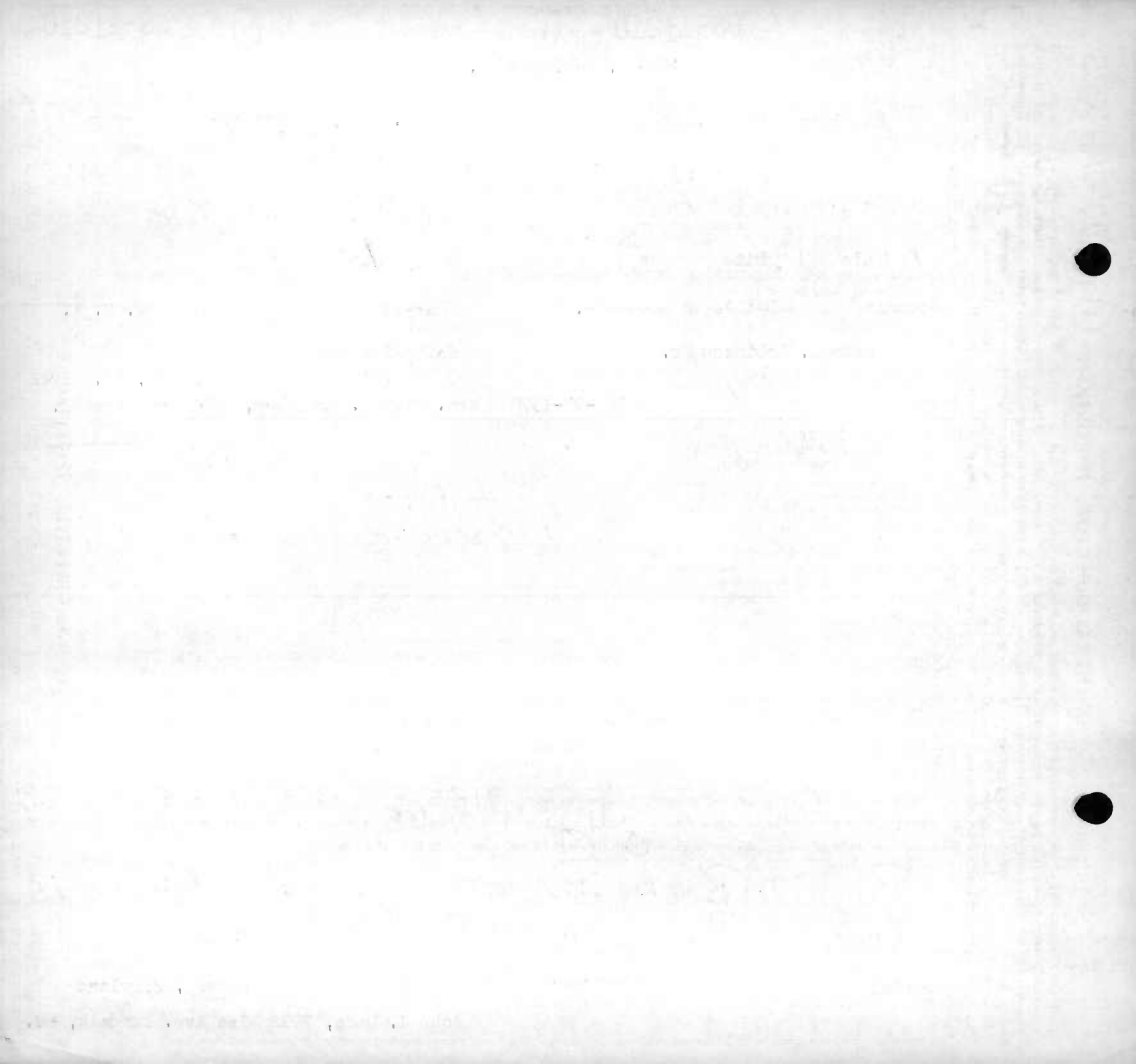
25B. NAME OF REGISTRAR

John J. Duda

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11211

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEONA WEST (<i>Leona</i>)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 5, 1968		Hour 11:05 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 728 N. Carrollton Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 5, 1968		Hour 11:05 A.M.
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Oct 12-1899		10. AGE (In years last birthday) 69	E. STREET AND NUMBER 728 N. Carrollton Avenue	
11. BIRTHPLACE (State or foreign country) Gloucester Va.		12. CITIZEN OF U.S.A.	13. FATHER'S NAME Samuel Griffin	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Margie Jackson
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-32-0634	18. INFORMANT Mary Ellis	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease		CAUSE OF DEATH Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> November 6, 1968 DATE SIGNED ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-10-68		24C. NAME OF CEMETERY or CREMATORY Zion poplars Cmt
24D. LOCATION (City, town, or county) (State) Gloucester Va.		24E. FUNERAL DIRECTOR Chas. C. Walker		24F. ADDRESS 1000 B. Miller St.
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR J. J. [illegible]		25C. ADDRESS 1000 B. Miller St.

90 91

WALLEY FOR
25/11/1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RITA CRONEY (Rita S.Croney)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 5, 1968 Hour 12:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 412 N. Belnord Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour November 5, 1968 12:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-02		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Oct. 12, 1890		10. AGE (In years last birthday) 78 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Shirey		14. STREET AND NUMBER 412 N. Belnord Avenue 24	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		14B. KIND OF BUSINESS OR INDUSTRY ---	
15. MOTHER'S MAIDEN NAME Margaret Clark		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) --	
17. SOCIAL SECURITY NO. 216-01-0172		18. INFORMANT Leroy L. Croney 412 N. Belnord Ave. (24)	
19. 412.7 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 6, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 9/68	
24C. NAME OF CEMETERY or CREMATORY Schwartz's Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Philip H. Hewigson	
25C. FUNERAL DIRECTOR ADDRESS 2024 Orleans St.			

VALLEY PARK
MAILING BOXES

Philip H. H. H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

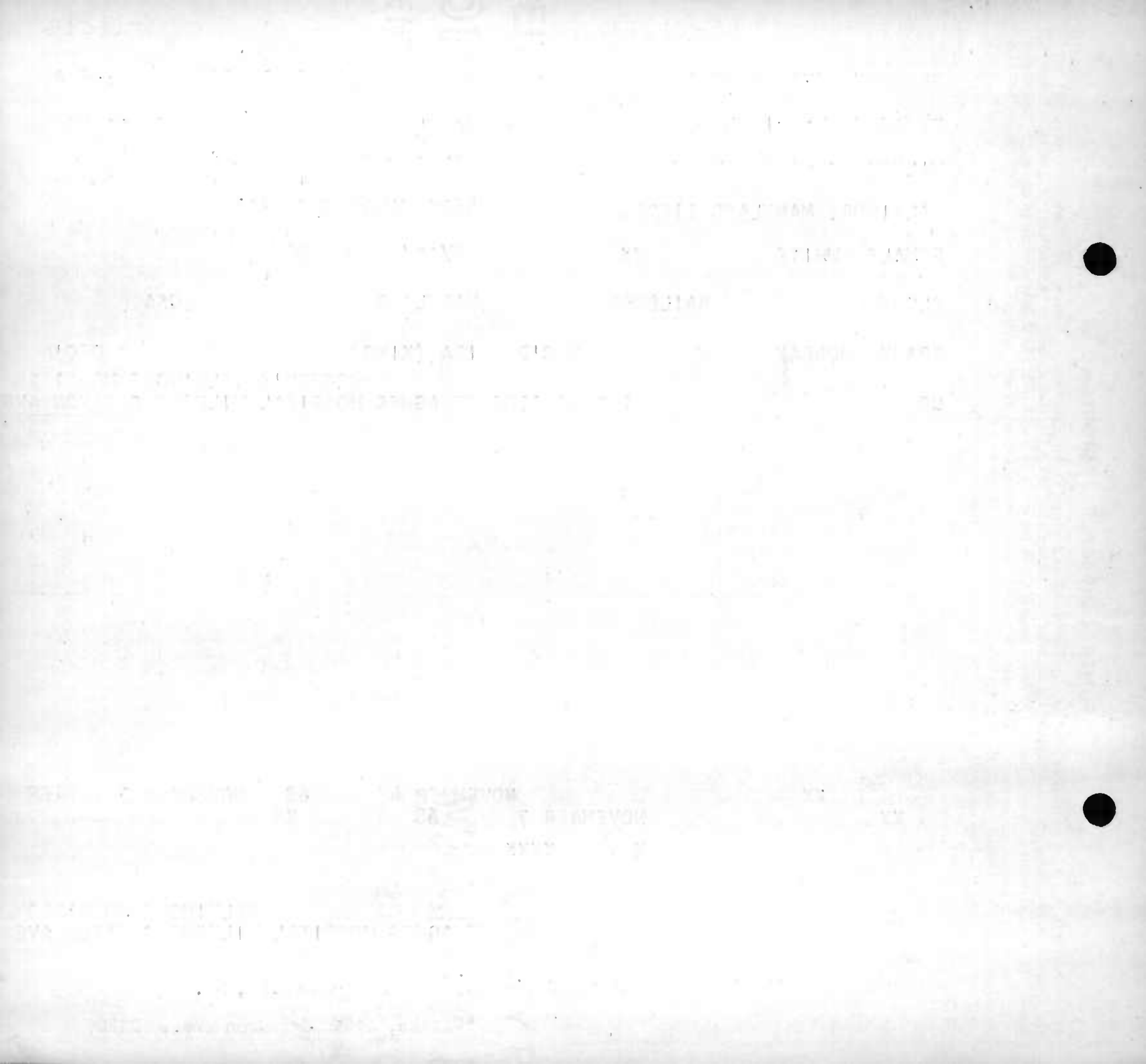
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) EUGENE HEILMAN Heilman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 7, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 508 Stamford Road		3. DATE PRONOUNCED DEAD Month Day Year Hour November 7, 1968 5:45 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/24/1900		10. AGE (In years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Retired	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-05-3307	
18. INFORMANT Mrs. Eugene Heilman		ADDRESS 508 Stamford Road	
19. CAUSE OF DEATH E880X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E900.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Cerebro-cranial injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 508 Stamford Road		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) between 12:00 & 5:00 A.M. 11-7-68	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell down basement stairs	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 7, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Witzke, 4101 Edmondson Aven., 21229	
25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Aven., 21229		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

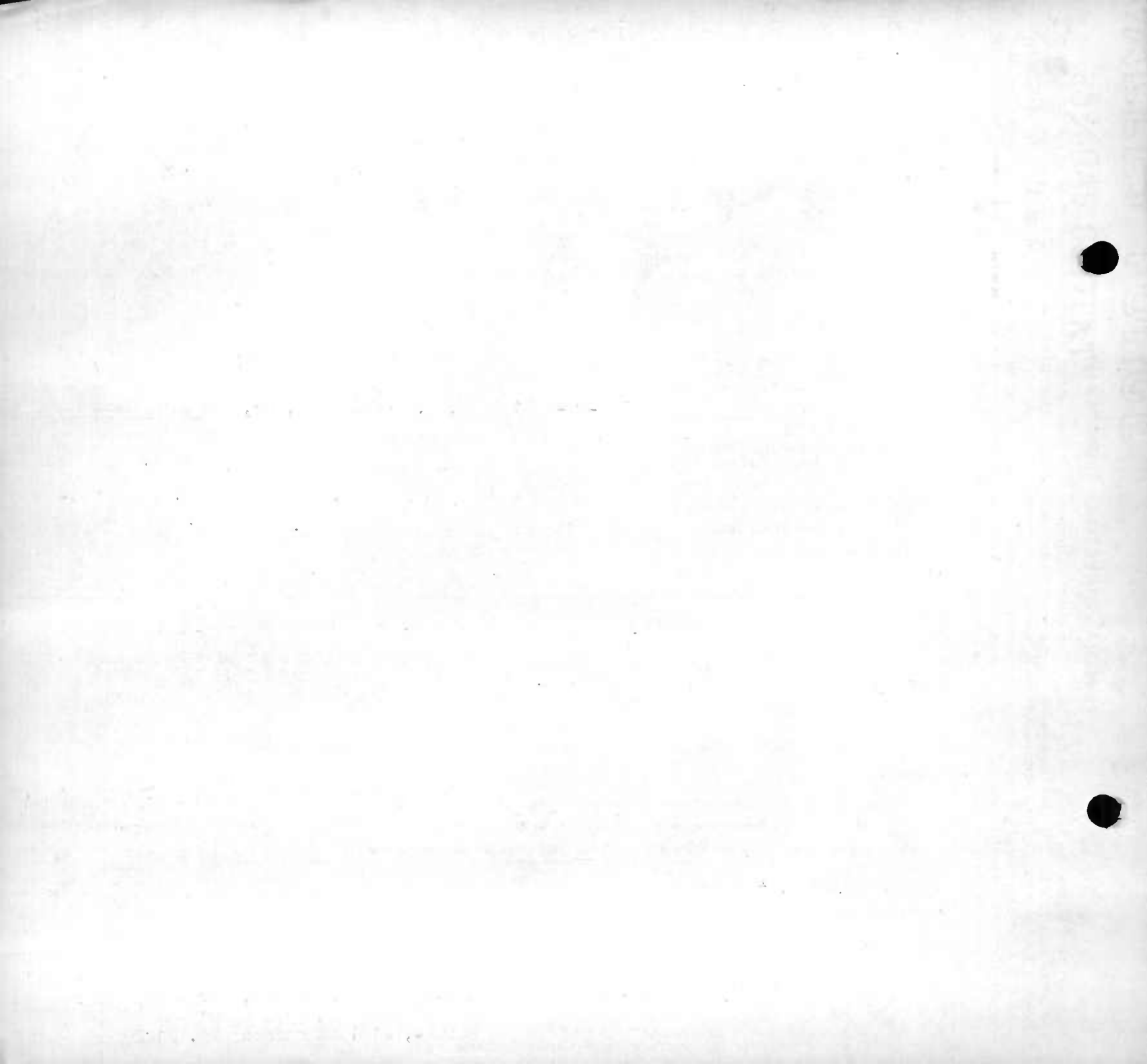
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11214
BIRTH NO. 1. NAME OF DECEASED (T) PROSKEY, EVA BARBARA		2. DATE AND HOUR OF DEATH NOVEMBER 7, 1968 5:05 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL <small>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> WILKENS & CATON AVENUES		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21229			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 06/12/00		9. AGE (In years lost birthday) 68		10. BIRTHPLACE (State or foreign country) MARYLAND	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13. STREET AND NUMBER BALTIMORE MARYLAND 21229		14. STREET AND NUMBER 4635 MANORDENE ROAD			
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		16. KIND OF BUSINESS OR INDUSTRY RAILROAD		17. FATHER'S NAME FRANK, MONDAY	
18. MOTHER'S MAIDEN NAME IDA (KING)		19. SOCIAL SECURITY NO. 202 01 1785			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		21. INFORMANT RECORD'S BALTIMORE MD 21229			
22. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> 410.9 I Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Circulatory collapse and respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Acute myocardial infarction			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
25. DATE OF OPERATION 0		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No)	
28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		29. DATE OF OPERATION			
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I certify that (X) (this hospital) attended the deceased from NOVEMBER 4, 1968 to NOVEMBER 7, 1968 , that (X) (we) last saw the deceased alive on NOVEMBER 7, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
37. SIGNATURE <i>L. Wong</i>		38. DATE SIGNED		39. PHYSICIAN'S NAME (Type) <i>Lee Man Wong</i>	
40. PHYSICIAN'S NAME (Type) <i>Lee Man Wong</i>		41. ADDRESS BALTIMORE MD 21229		42. ST AGNES HOSPITAL WILKENS & CATON AVE	
43. BURIAL CREMATION, REMOVAL (Specify) Burial		44. DATE 11/9/68		45. NAME OF CEMETERY or CREMATORY Cedar Bluff Cemetery	
46. LOCATION (City, town, or county) (State) Annapolis, Md.		47. DATE REC'D BY HEALTH DEPT. NOV 8 1968			
48. NAME OF REGISTRAR <i>Witzke</i>		49. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11215
BIRTH NO. 1. NAME OF DECEASED (Type or Print) BERNARD C. AUER		2. DATE AND HOUR OF DEATH 11-7-68 11 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BOW SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1805 WILKENS AVE.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-92	9. AGE (In years last birthday) 45 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME W. T. AUER		14. MOTHER'S MAIDEN NAME SALLY WELLS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-8521		17. INFORMANT ADDRESS Mr. B. Cecil Auer, Jr., 2131 Southland Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 II Constrictive heart failure Antecedent Causes Coronary artery disease Old & recent myocardial infarct		19. CAUSE OF DEATH Approximate interval between onset and death 420.1 II St. p. aortic graft for aneurysm			
19A. DATE OF OPERATION 11-4-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED St. p. aortic graft for aneurysm		20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from 10-14-68 19 to 11-7-68 19 68, that (I) (we) last saw the deceased alive on 11-7-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE U. Sangkum 23C. PHYSICIAN'S NAME (Type) U. SANGKUM				23B. DATE SIGNED 11-7-68 23D. ADDRESS B3H	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D. BY HEALTH DEPT. NOV 8 1968 25B. NAME OF REGISTRAR Witzke, 4101 Edmondson Ave. 21229 25C. FUNERAL DIRECTOR ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO.

68-11216

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

PAUL MILLER

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

November 1, 1968

4:45 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)
OR INSTITUTION

JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 1, 1968

4:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Grounds

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

914 D. Street, Aberdeen Proving Grounds

9. DATE OF BIRTH

3/23/43

10. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul H. Miller

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Soldier

14B. KIND OF BUSINESS OR INDUSTRY

U.S. Army

15. MOTHER'S MAIDEN NAME

Dorothy Loudon

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)
yes17. SOCIAL
SECURITY NO.

217-38-6388

18. INFORMANT

U. S. Army Records

ADDRESS

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rte. #7 1 mile North of U.S. Rte. 695

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) Nov. 1, 1968 3:10 A.M.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Driver in auto fixed collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/6/68

24C. NAME OF CEMETERY or CREMATORY

Garden of Memory

24D. LOCATION (City, town, or county)

Tampa, Fla.

25A. DATE REC'D BY HEALTH DEPT.

NOV 8 1968

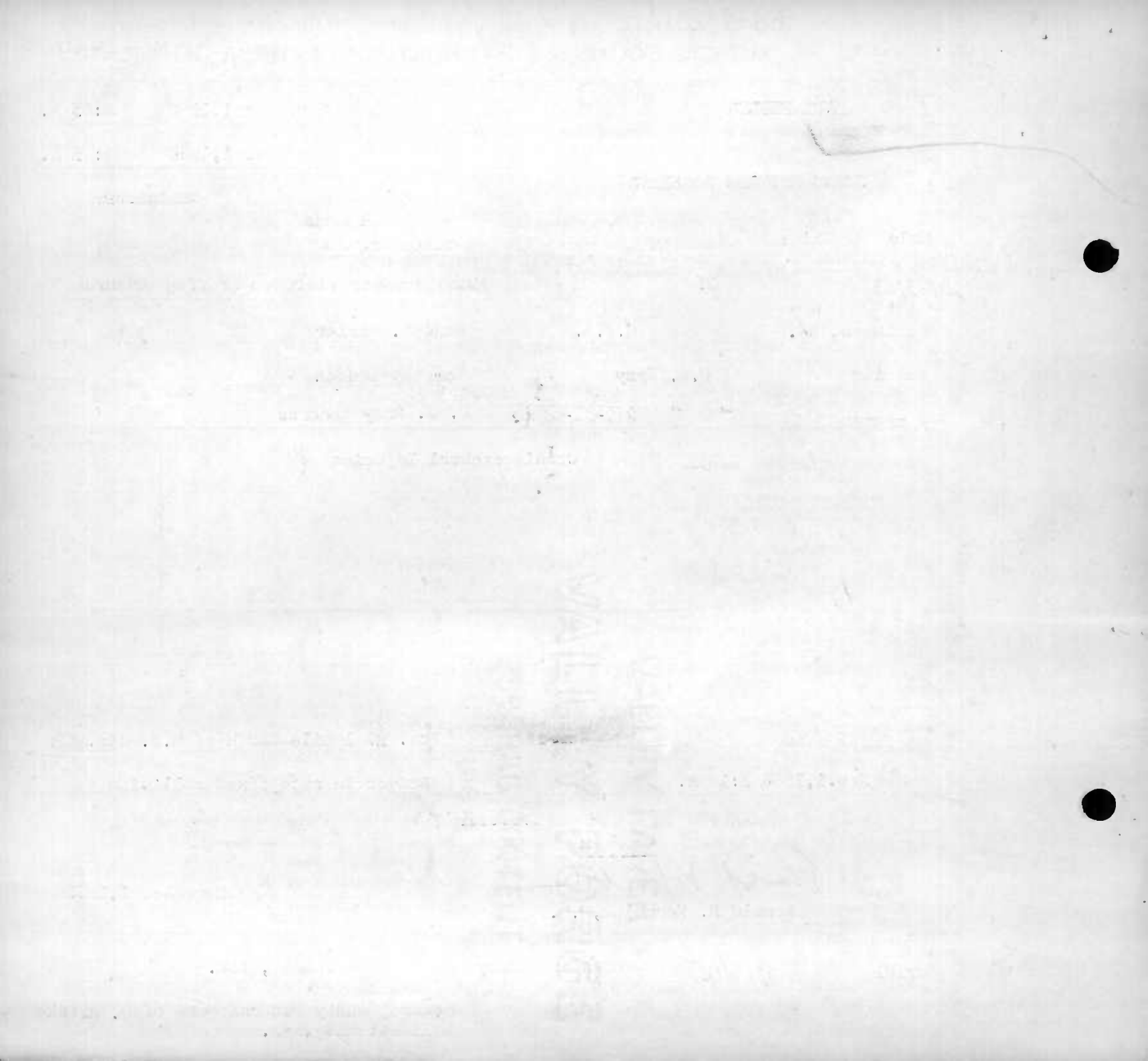
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard County Funeral Home of H. Witzke
Ellicott City, Md.

ADDRESS



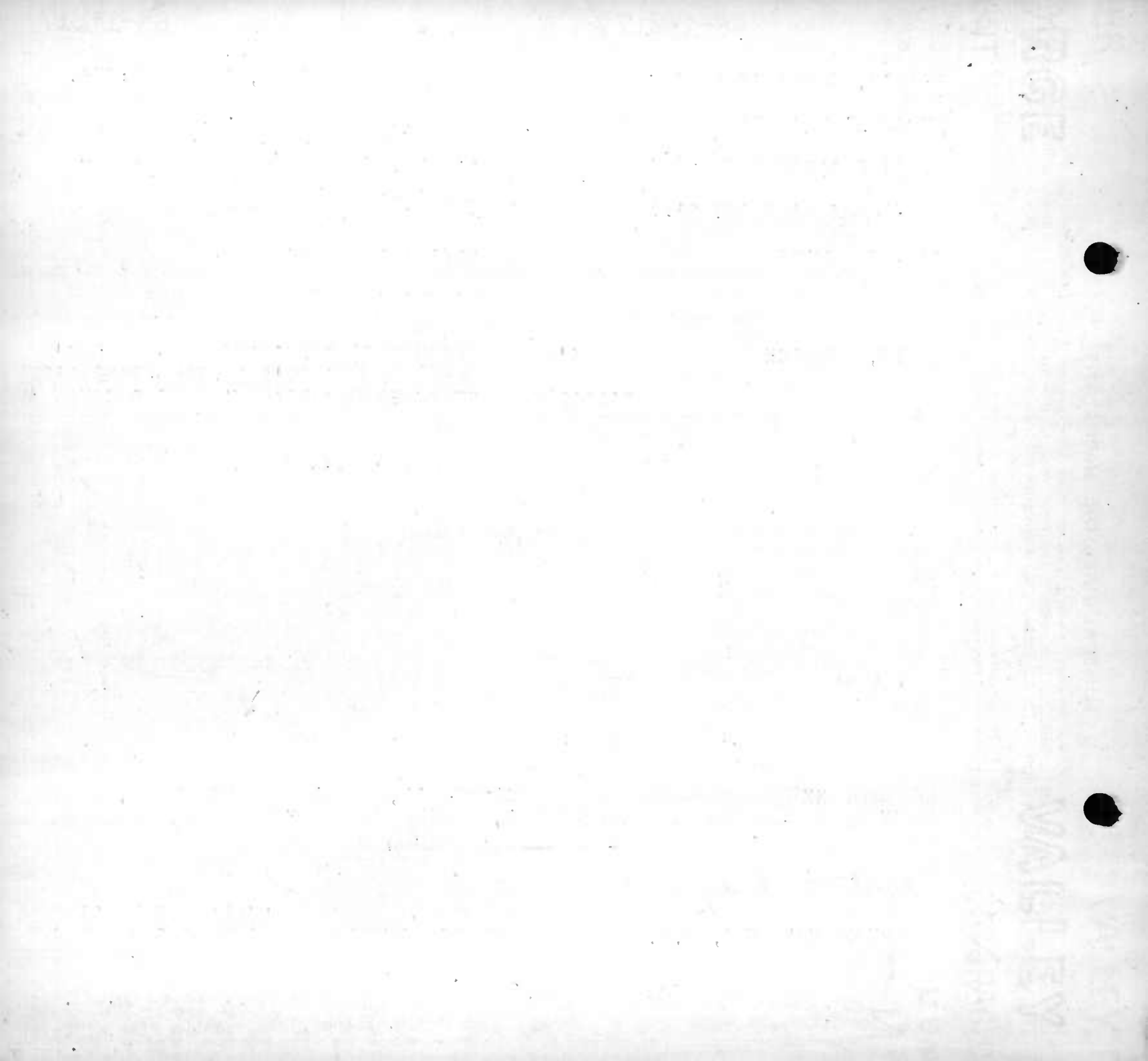
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11217 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68-11217

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCE, FLORENCE ELEANOR		2. DATE AND HOUR OF DEATH NOVEMBER 5, 1968 2:55A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS & CATON AVENUES		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 21228		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 02/17/83		9. AGE (In years last birthday) 85		10. BIRTHPLACE (State or foreign country) MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEWIS, HAMRICK	
14. MOTHER'S MAIDEN NAME (ISANOGLE) CATHERINE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212017452	
17. INFORMANT RECORD'S BALTIMORE		18. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE		19. DATE 21229	
19. DATE OF OPERATION None		20. AUTOPSY? (Yes or No) No		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (this hospital) attended the deceased from OCTOBER 11, 1968 to NOVEMBER 5, 1968 , that (we) last saw the deceased alive on NOVEMBER 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE Morton B. Blumberg, M.D.		24. DATE SIGNED Nov. 5, 1968	
25. DATE REC'D BY HEALTH DEPT. NOV 8 1968		26. NAME OF REGISTRAR St. Johns Cem.		27. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 425		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11218	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MAMIE WILKINS		2. DATE AND HOUR OF DEATH 10/28/68		1:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 1001			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSP. BALTIMORE MD 21205		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1236 N. EDEN ST. 21213			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-29-91	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Dorchester, Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN KEENE		14. MOTHER'S MAIDEN NAME ELLEN BANKS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Family 1236 N. Eden St 21213	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 40 MIN. 4+ YEARS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 433.0 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from OCT 27 1968 to OCT. 28 1968 , that (1) (we) last saw the deceased alive on OCT. 28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Sobot		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED OCT. 28, 1968	
23C. PHYSICIAN'S NAME (Type) DR. 50 DOT KA		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) 11/5/68		24B. DATE Nov 5/68		24C. NAME OF CEMETERY or CREMATORY Old Field Cemetery Cambridge Md	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Rafael Williams	
25C. FUNERAL DIRECTOR 17014 B...		25D. ADDRESS			

NO. 10

CAROL ANN

AS-ND

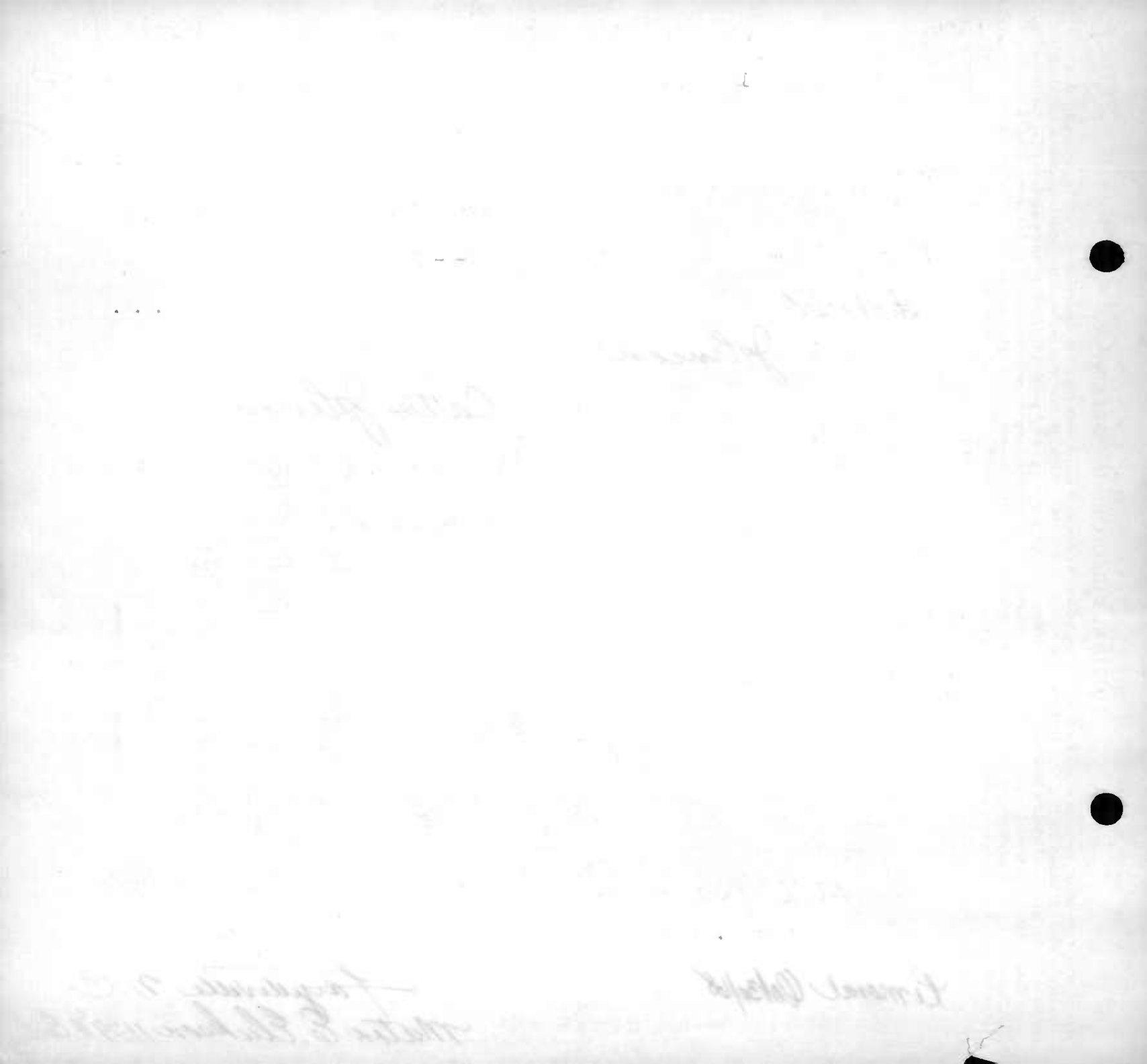
NO

DET. 24
O.T. 21

20 OCT 1964

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11219				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11219	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) John H. Johnson			
2. DATE AND HOUR OF DEATH 10/25/68 4:03 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 1639 Barnes Street Baltimore 21205			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 5-3-13	
9. AGE (In years lost birth day) 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Johnson				14. MOTHER'S MAIDEN NAME Cattie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Cattie Johnson ADDRESS	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) Pneumonia, post-op (B) CARCINOMA of ESOPHAGUS (C) INTERVAL BETWEEN ONSET AND DEATH 36 hours							
19. 150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10/22/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of ESOPHAGUS		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/4/68 1968 to 10/25 1968, that (I) (we) last saw the deceased alive on 10/25/ 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Clarence W. Gehris, J. M.D.				23B. DATE SIGNED 10/25/68		23C. PHYSICIAN'S NAME (Type) Clarence W. Gehris	
23D. ADDRESS The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Limorial		24B. DATE 10/30/68		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Fayetteville N.C.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Not a Medical Examiner's Case per Dr. Springate
MEDICAL CERTIFICATION

BIRTH NO. 68-11220				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 68-11220		
1. NAME OF DECEASED (Type or Print) Williams, Benjamin				2. DATE AND HOUR OF DEATH 10/24/68		9:00 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 920 E. Preston St.						
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 7/20/21	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Isiah Williams			14. MOTHER'S MAIDEN NAME Mrs. Mary Harrison							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mary Williams				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-7-7-01			CAUSE OF DEATH (A) pancreatitis, possibly toxic DUE TO (B) severe trauma DUE TO (C) aspiration pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3+ days 2 days 3-2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
19A. DATE OF OPERATION 5-8-7-0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/23 19 68 to 10/24 19 68 , that (I) (we) last saw the deceased alive on 10/24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE David L. Jackson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/24/68				
23C. PHYSICIAN'S NAME (Type)			M.D. David L. Jackson		23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
Buried Oct 29/68				East Nat Cem		5501 Tridway				
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR David L. Jackson		25C. FUNERAL DIRECTOR Milton E. Elchert		ADDRESS 1129 N. Calver				

3 days	penicillin, 100,000 units
2 days	bellum, 100,000 units
3 days	aspirin, 100,000 units

QVA

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED ON APPROVAL FOR THE MEDICAL EXAMINERS OFFICE BY DR. SPITZ
MEDICAL CERTIFICATION

BIRTH NO. 5-530		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11221	
M.E. CASE NO.		68-11221		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY Josephine Smith			2. DATE AND HOUR OF DEATH 11-5-68 10:00 A.M.		
3. PLACE OF DEATH BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 240 Chestnut St.		
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-02-10	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lunenburg Co., Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME SAMUEL H. STOKES		
14. MOTHER'S MAIDEN NAME MARTHA ANN WILSON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT THOMAS Mr. Eddie Smith		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH E932.0 Hemorrhage (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. E946X II laceration of inf vena cava during renal bx OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19A. DATE OF OPERATION 11-5-68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Renopentential bleed		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 07-05		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-5-68 to 11-5-68 and that (I) (we) last saw the deceased alive on 11-5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Ronald C Michels MD			23B. DATE SIGNED 11-5-68		
23C. PHYSICIAN'S NAME (Type) Ronald Michels, M.D.			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-10-68		24C. NAME OF CEMETERY or CREMATORY Stokes Cemetery	
24D. LOCATION Meherin,		24E. (City, town, or county) (State) Virginia			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTON & DRETT F.H.	
25D. ADDRESS 1701 Laurens					

11-2-68 Isotretinoin blood

Barold & Minkley MD

x

11-2

11-2

11-2

11-2-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11222	
B-650 68-11222				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BROWN, ULYSES				2. DATE AND HOUR OF DEATH NOV. 6, 1968 4:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVE BALTO MD 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 226 N HILTON ST	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 04 14	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR			11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME RICHARD BROWN			14. MOTHER'S MAIDEN NAME BELLE (HUTCHINSON)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 248169079		17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage (R) hemiparesis softening + extension of # C (R) cerebral thrombosis (probable)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days? 10 days?		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 332X II History of epilepsy					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT 26 19 68 to NOV. 6 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on NOV. 6 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>R. Widmeyer</i> DEGREE				23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) R. WIDMEYER DEGREE				23D. ADDRESS ST AGNES HOSP. BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-11-68		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens Street <i>Montana Dyett E. H.</i>			

1900

W. F. F. F. F.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-11223	
E-120 68-11223											
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) JOHN EPPS						2. DATE AND HOUR OF DEATH November 6, 1968 M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore City					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) George Washington Carver Nursing Home						C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1503 N. Decker Avenue											
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/1889		9. AGE (In years last birthday) 79		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Brunswick County Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Epps						14. MOTHER'S MAIDEN NAME Willie Jolley					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Wilson Epps				ADDRESS 1503 N. Decker Ave. Baltimore, Maryland	
18. 472.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Gen. Arterio Sclerosis (C) Arterio Sclerosis Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours Unknown Unknown					
MEDICAL CERTIFICATION 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/1/68 to 11/6/68, that (I) (we) last saw the deceased alive on 11/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE E. E. Holt						23B. DATE SIGNED 11/7/68				23C. PHYSICIAN'S NAME (Type) F. E. Holt	
23D. ADDRESS 3715 Liberty Hts. Ave.											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE		24C. NAME OF CEMETERY or CREMATORY Jennings Cemetery				24D. LOCATION (City, town, or county) (State) Victoria County, Virginia	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968				25B. NAME OF REGISTRAR R. E. Holt				25C. FUNERAL DIRECTOR Morton D. Drett Funeral Homes, Inc. 1701 E. Johns St., Baltimore, Md.			

CVA

Car. Petrus Schuur

Petrus Schuur (handwritten)

Cham. Schuur (handwritten)

No

1/1/1 1/1/1 1/1/1 1/1/1

Collect

F. E. Holt

2000 1/1/1/1/1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11224

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CARRIE (PIPENS) L. PIPPENS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 6, 1968 9:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1913 Ettings Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 6, 1968 9:50 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8-30-12		10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Turner		14. STREET AND NUMBER 1913 Ettings Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Matilda Davis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Howard Turner		ADDRESS 1509 Ensor St.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 6, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) 11-Burial		24B. DATE 11-10-68	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

RECEIVED JUL 1951

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WALL LITE

WALL LITE

WALL LITE

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WALL LITE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11225 CERTIFICATE OF DEATH

REG. NO. 68-11225

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Garland Brown</i>		2. DATE AND HOUR OF DEATH <i>11-1-1968</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>417 E. Lanvale St</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>	6. RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-20-1905</i>		9. AGE (In years last birthday) <i>65</i>
10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Mc Norton</i>			14. MOTHER'S MAIDEN NAME <i>Anna Belle Mc Norton</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Brown</i> ADDRESS <i>417 E. Lanvale St</i>	
18. <i>238.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Brain Tumor</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain Tumor</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 MONTHS</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>237X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1, 1968</i> to <i>Nov. 1, 1968</i> , that (I) was last saw the deceased alive on <i>Nov. 1, 1968</i> and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE <i>Maurice L. Adams</i> DEGREE <i>MD</i>				23B. DATE SIGNED <i>11-4-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>MAURICE L. ADAMS</i>		23D. ADDRESS <i>238 N. Carey St. Balt. Md</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-5-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ark. Brutus Memorial Park</i>	
24D. LOCATION (City, town, or county) <i>Balt. Co. Md</i>		24E. LOCATION (State) <i>Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1968</i>		25B. NAME OF REGISTRAR <i>Rayner Sanders</i>		25C. FUNERAL DIRECTOR ADDRESS <i>217 E. Preston St</i>	

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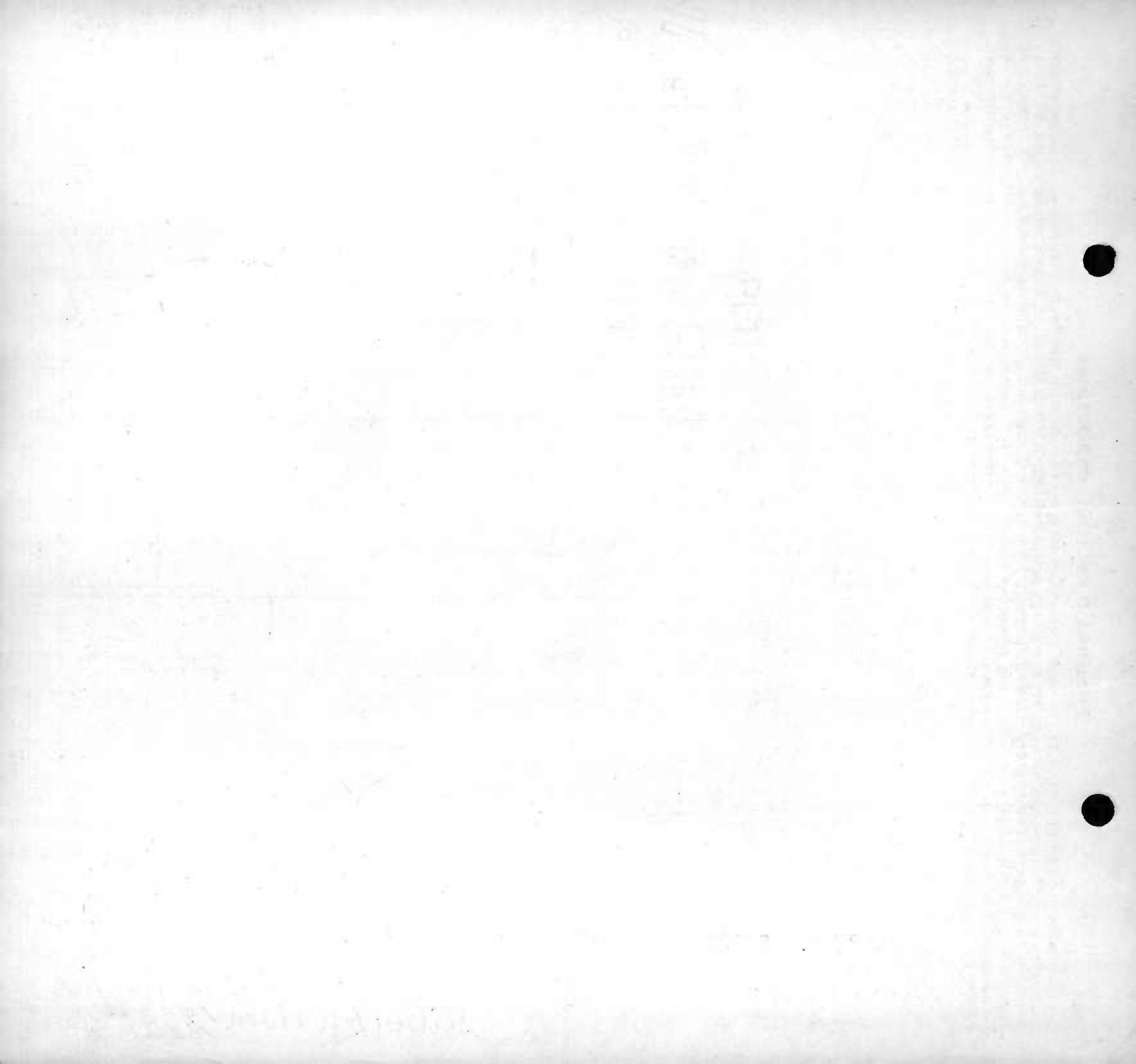
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11226	
BIRTH NO. 5-315		68-11226		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY STEPHENS			2. DATE AND HOUR OF DEATH 11/3/68 8:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEN. HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN BALTE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2401 MONTEBELLO TERRACE		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/86	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carnine Arrest (B) DISEASE OR CONDITION DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia Primary Enceph. (C)		
19. 491X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/30/68 19 68 to 11/3 19 68, that (I) (we) last saw the deceased alive on 11/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen D. Jensen M.D.			23B. DATE SIGNED 11/3/68		23C. PHYSICIAN'S NAME (Type) ALLEN D. JENSON M.D.
23D. ADDRESS UNION MEN. HOSP.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11-6-68			24C. NAME OF CEMETERY or CREMATORY Libertus		
24D. LOCATION Libertus Balt. Md			24E. LOCATION (City, town, or county), (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968			25B. NAME OF REGISTRAR Robert E. Jenkins		
25C. FUNERAL DIRECTOR			25D. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11227	
BIRTH NO.		68-11227		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELIJAH NIXON SR		2. DATE AND HOUR OF DEATH 11/6/68 9:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 314 East 20th Street, 21218			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/16/07	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME William Nixon		14. MOTHER'S MAIDEN NAME Eliza Ellen Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 246-07-0376		17. INFORMANT Mrs. Parmillie Nixon 314 E. 20th St. 21218	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF PANCREAS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARCINOMA OF PANCREAS DUE TO (B) 9 MONTHS DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
18. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from 11-1-1968 to 11-6-1968 , that (1) last saw the deceased alive on 11-6-1968 and that it is (my) four opinion death occurred on the date and hour and from the causes stated above (1) did (did not) view the body after death.					
23A. SIGNATURE Michael D. Lutz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) MICHAEL D. LUTZ		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-9-1968		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall Jones, Jr. 21213	

CHRONOLOGICAL OF EVENTS

11/10/88

MICHAEL D. LUTZ
Michael D. Lutz

FUNERAL DIRECTOR: IMPORTANT

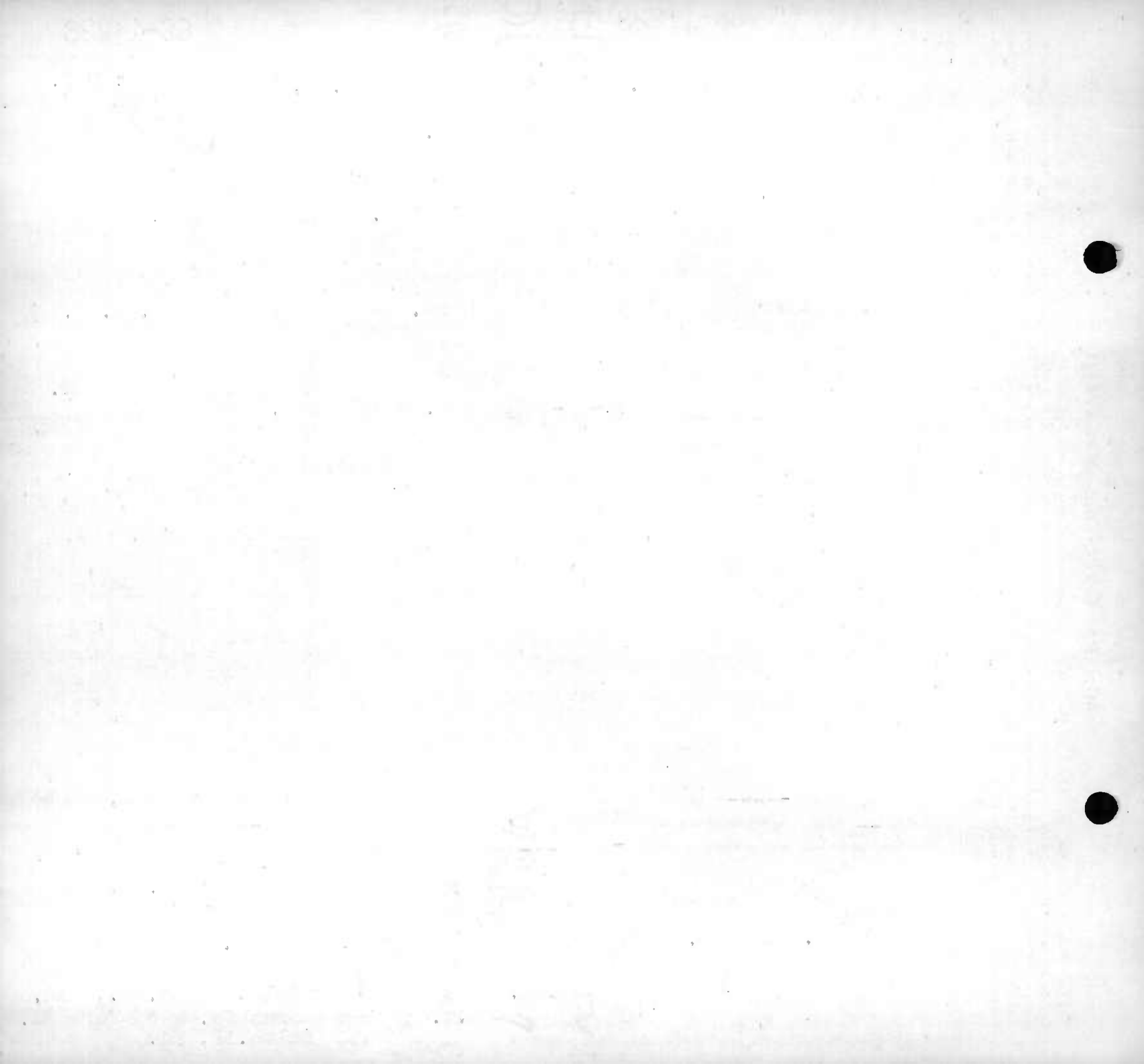
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11228

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Albert F. Morse		Nov. 4, 1968 8:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 1661 E. Cold Spring Lane			Md. 27-09		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore 21218		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1661 E. Cold Spring Lane		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/2/1895	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Manager		5 & 10¢ Store		Mass.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Morse			Alice		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		155-03-7982		2803 Kingsridges Rd. Mrs. Priscilla I. Adkins 21234	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. 4 10.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Due to, or as a consequence of: Acute myocardial infarction 10 min. (B) Arteriosclerotic cardiovascular disease 10 yrs. Due to, or as a consequence of: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 19 66 to November 4, 19 68, that (I) (we) last saw the deceased alive on October 29, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor				23B. DATE SIGNED Nov. 7, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor				23D. ADDRESS 3902 Greenmount Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/7/68		Moreland Mem. Park	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
Parkville, Balto. Co., Md.		NOV 8 1968			
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		25C. ADDRESS	
H.W. Jenkins & Sons Co.		4905 York Rd.		Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11229

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Earl G. Gill, SR.		2. DATE AND HOUR OF DEATH 11-5-68 7:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 27-09		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hospital			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4301 Loch Raven Blvd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-19-92	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE - CONTRACTOR		10B. KIND OF BUSINESS OR INDUSTRY GILL-SIMPSON INC.		11. BIRTHPLACE (State or foreign country) BALTO. CO. Md.	
13. FATHER'S NAME William B. Gill			14. MOTHER'S MAIDEN NAME Delia M. Petticord		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-05-2011		17. INFORMANT Margaret K. Gill	
				ADDRESS (Same)	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma Tosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca of Prostate			(B) DUE TO, OR AS A CONSEQUENCE OF: Urinary Tract Infection		
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-25 1968 to 11-5 1968 , that (I) (we) last saw the deceased alive on 11-5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Delfa C. Gomez, M.D.				23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) Dr. Delfa C. Gomez,				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/68		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville, Balto. Co. Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11230 CERTIFICATE OF DEATH

REG. NO. 68-11230

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Elizabeth G. Ellingsworth</u>		2. DATE AND HOUR OF DEATH <u>11/17/68</u> <u>1:32 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3900 N. Charles St.</u>	
S. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/88</u>		9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CENTREVILLE Maryland</u>	
13. FATHER'S NAME <u>Frank Gemmell</u>			14. MOTHER'S MAIDEN NAME <u>Agatha Wilson Lida Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-8223B</u>		17. INFORMANT <u>Mervin H. Ellingsworth (same)</u>	
18. <u>207.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Leukemia Pancytopenia 2-3 mos.</u> (B) <u>Cirrhosis of Liver, Splenomegaly 3 yrs.</u> (C) <u>Arteriosclerotic Heart Disease 3 yrs.</u>			
19. DATE OF OPERATION <u>204.4</u> II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>10/24</u> 19 <u>68</u> to <u>11/17</u> 19 <u>68</u> , that (1) <u>we</u> last saw the deceased alive on <u>11/17</u> 19 <u>68</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles Robert Goshen</u>				23B. DATE SIGNED <u>11/17/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles Robert Goshen</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/11/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>			
25B. NAME OF REGISTRAR <u>W. J. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>			

Q15

WILLIAM



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11231 -

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11231

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALLCUTT, DANIEL WALTER		2. DATE AND HOUR OF DEATH 11/6/68 9:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 9-01		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEM. HOSP.			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3801 GREEN MOUNT AVE.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED Clerk		10B. KIND OF BUSINESS OR INDUSTRY Home Building		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WALTER Allcutt		
14. MOTHER'S MAIDEN NAME ELIA COX			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		
16. SOCIAL SECURITY NO. 22-16-1590			17. INFORMANT Alice Jewell 3801 Greenmount Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I Cerebral metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 162.1 II Bronchogenic Carcinoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION MARCH 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DRAINAGE		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 11/2 19 68 to 11/6 19 68 , that (I) (we) last saw the deceased alive on 11/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alice Jewell MD DEGREE				23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) ALLAN D. JENSEN, M.D. DEGREE				23D. ADDRESS UNION MEM. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY Chester Cemetery	
24D. LOCATION (City, town, or county) (State) Chester Town, Kent Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968			
25B. NAME OF REGISTRAR Wm Cook - Brooks, Inc.		25C. FUNERAL DIRECTOR ADDRESS BALTO. MD.			

ADULTS PAID 50¢

CHILDREN UNDER 10 25¢

Class 100-1000

White House

100-1000

100-1000

100-1000

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11232 CERTIFICATE OF DEATH

REG. NO. 68-11232

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PEDDICORD, Robert Eugene		2. DATE AND HOUR OF DEATH 3 NOVEMBER 1968 3:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE, CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-3-21		9. AGE (In years last birthday) 46		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK HANDLER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JERRY PEDDICORD		14. MOTHER'S MAIDEN NAME RUBY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10-29-42 TO 1-2-46		16. SOCIAL SECURITY NO. 212-20-8147		17. INFORMANT VET ADMIN HOSP RECORDS ADDRESS 3900 LOCH RAVEN BLVD., BALTO., MD 21218	
18. 590.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronis pyelonephritis (B) DUE TO, OR AS A CONSEQUENCE OF: Uremia (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Mo. 4 YEARS 4 YEARS			
19. 600.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 27 OCTOBER 19 68 to 3 NOVEMBER 19 68 , that (B) (we) last saw the deceased alive on 3 NOVEMBER 19 68 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Paul E. Chenoweth Jr.</i> DEGREE				23B. DATE SIGNED November 4, 1968	
23C. PHYSICIAN'S NAME (Type) DEGREE		23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial/Crypt 11/7/68		24B. DATE 11/7/68		24C. NAME OF CEMETERY or CREMATORY MORELAND MEM. PARK	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR <i>Paul E. Chenoweth Jr.</i>		25C. FUNERAL DIRECTOR ADDRESS Paul E. Chenoweth Jr. 3617 Chestnut Ave	

1840 - 1841

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11233

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11233

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SMITH, MILTON THOMAS

2. DATE AND HOUR OF DEATH

11/4/68

5:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSP
832 E CALVERT STS
BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3605 KESWICK Rd.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/23/08

9. AGE (In years last birthday)

60

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DETECTIVE

10B. KIND OF BUSINESS OR INDUSTRY

PINKERTON

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

EDWARD SMITH

14. MOTHER'S MAIDEN NAME

SADIE CALAWAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-01-6932

17. INFORMANT

MRS CARRIE SMITH

ADDRESS

(SAME)

18.

410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Infarct

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary congestion

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/1 19 68 to 11/4 19 68, that (I) (we) last saw the deceased alive on 11/4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

ALLAN D. JENSEN

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

ALLAN D. JENSEN

DEGREE

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/68

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

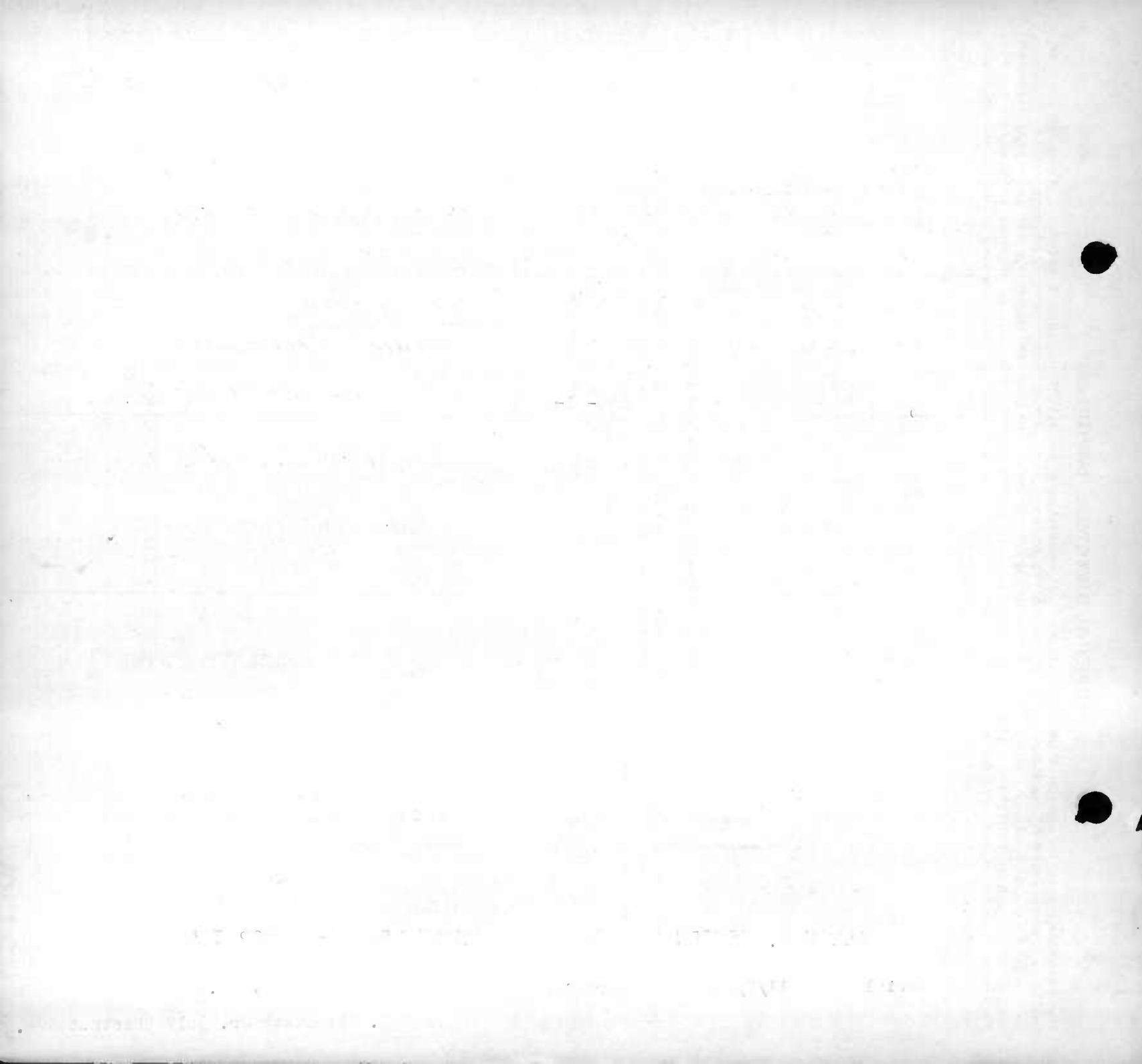
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Paul E. Chenoweth Jr. 3617 Chestnut Ave.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11234

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID A. WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year November 4, 1968		Hour 3:15 A.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 4, 1968		
6. SEX Male		7. RACE White		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13 07
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 1/1/02		10. AGE (In years last birthday) 66		E. STREET AND NUMBER 718 Berry Street
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ?
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		14B. KIND OF BUSINESS OR INDUSTRY Courthouse		15. MOTHER'S MAIDEN NAME ?
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212-07-4267		18. INFORMANT Edna M. Williams (same)
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1				
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 4, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/7/68		24C. NAME OF CEMETERY or CREMATORY St. Mary's
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		
25B. NAME OF REGISTRAR Paul E. Chenoweth Jr.		25C. FUNERAL DIRECTOR Paul E. Chenoweth Jr.		
25D. ADDRESS 3617 Chestnut Ave.				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11235 CERTIFICATE OF DEATH

REG. NO. 68-11235

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ELIZABETH E. RUMPF</u>		2. DATE AND HOUR OF DEATH <u>November 6th 6:05 M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1622 N. Regester St.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/09/1885</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harold Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lysa ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>212 012804</u>		17. INFORMANT <u>Mr Wilbert Beigel 8512 Willow Oak Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS</u>		CAUSE OF DEATH <u>CARCINOMA of COLON</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Leukemia</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Leukemia</u>		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. DATE OF OPERATION <u>11-3-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Leukemia</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>September 5th 1968</u> to <u>November 6th 1968</u> , that (I) (we) last saw the deceased alive on <u>November 6th 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Gern</u>		23B. DATE SIGNED <u>11/6/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael Gern</u>	
23D. ADDRESS <u>Maryland General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>11/9/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1968</u>		25B. NAME OF REGISTRAR <u>Regester</u>		25C. FUNERAL DIRECTOR <u>Henry Sander & Sons Inc.</u>	
25D. ADDRESS <u>Baltimore Maryland 21213</u>					



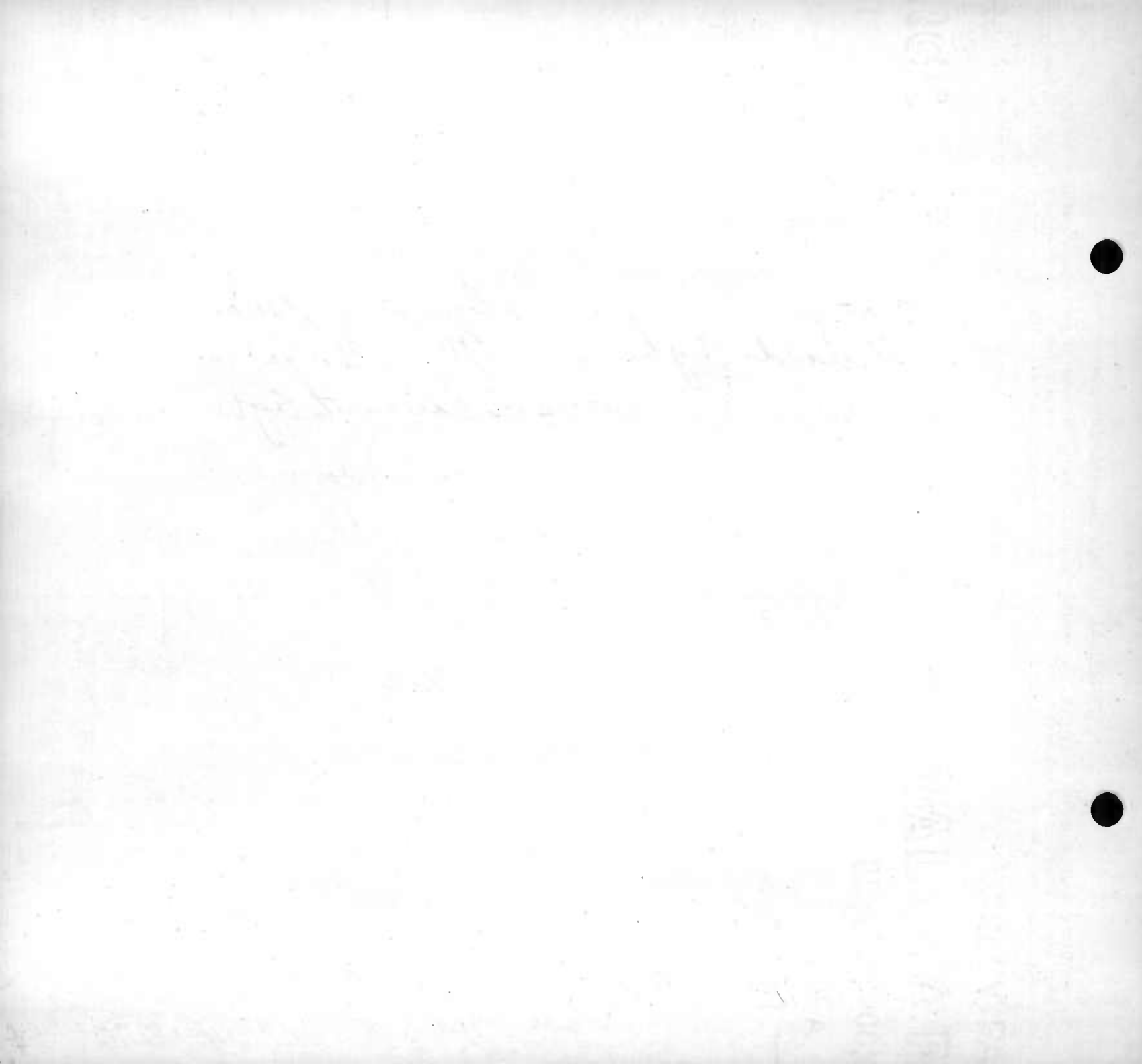
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11236 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11236

BIRTH NO.		1. NAME OF DECEASED (Type or Print) OGBURN WALTER		2. DATE AND HOUR OF DEATH 11-4-1968 8.25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-09 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4030 WOODHAVEN AVE - 21216		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1910	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Edward Ogburn		14. MOTHER'S MAIDEN NAME Mary E. Tolson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-014436		17. INFORMANT Elizabeth Ogburn	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.V.A. Subarachnoid (B) haemorrhage, Pulmonary oedema, (C) H.A.S.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 62 hrs			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from 11-1- 19 68 to 11-4- 19 68 , that we (we) lost saw the deceased alive on 11-4- 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did) view view the body after death.					
23A. SIGNATURE P. P. Joshi M.D.				23B. DATE SIGNED 11-4-1968	
23C. PHYSICIAN'S NAME (Type) P. P. JOSHI M.D.				23D. ADDRESS 730 ASHBURTON ST., BALTIMORE - 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch.	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. LOCATION (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1968		25B. NAME OF REGISTRAR John G. Sullivan		25C. FUNERAL DIRECTOR William J. Phillips	
25D. ADDRESS 1727 Monmouth					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11237

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **WALTER J. McLAURIN**

2. DATE OF DEATH Known ☐ Month Day Year **November 5, 1968** Hour **11:55 A.** Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour **November 5, 1968 11:55 A.** M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland** B. COUNTY

6. SEX **Male** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **7-8-1923** 10. AGE (In years last birthday) **45** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER **2438 Keyworth Avenue**

11. BIRTHPLACE (State or foreign country) **North Carolina** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **James Mc Laurin**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

15. MOTHER'S MAIDEN NAME **Catherine Mc Milland**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS **Amy Carbett 5014 Palmer Ave**

19. **E9651X**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

CAUSE OF DEATH

Gunshot wound of Head

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Taxicab**

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? **2600 Blk, Kent Avenue- Taxicab**

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) **Nov. 5, 1968 11:25 P.m.**

22E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Gunshot wound of head

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **November 6, 1968**

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

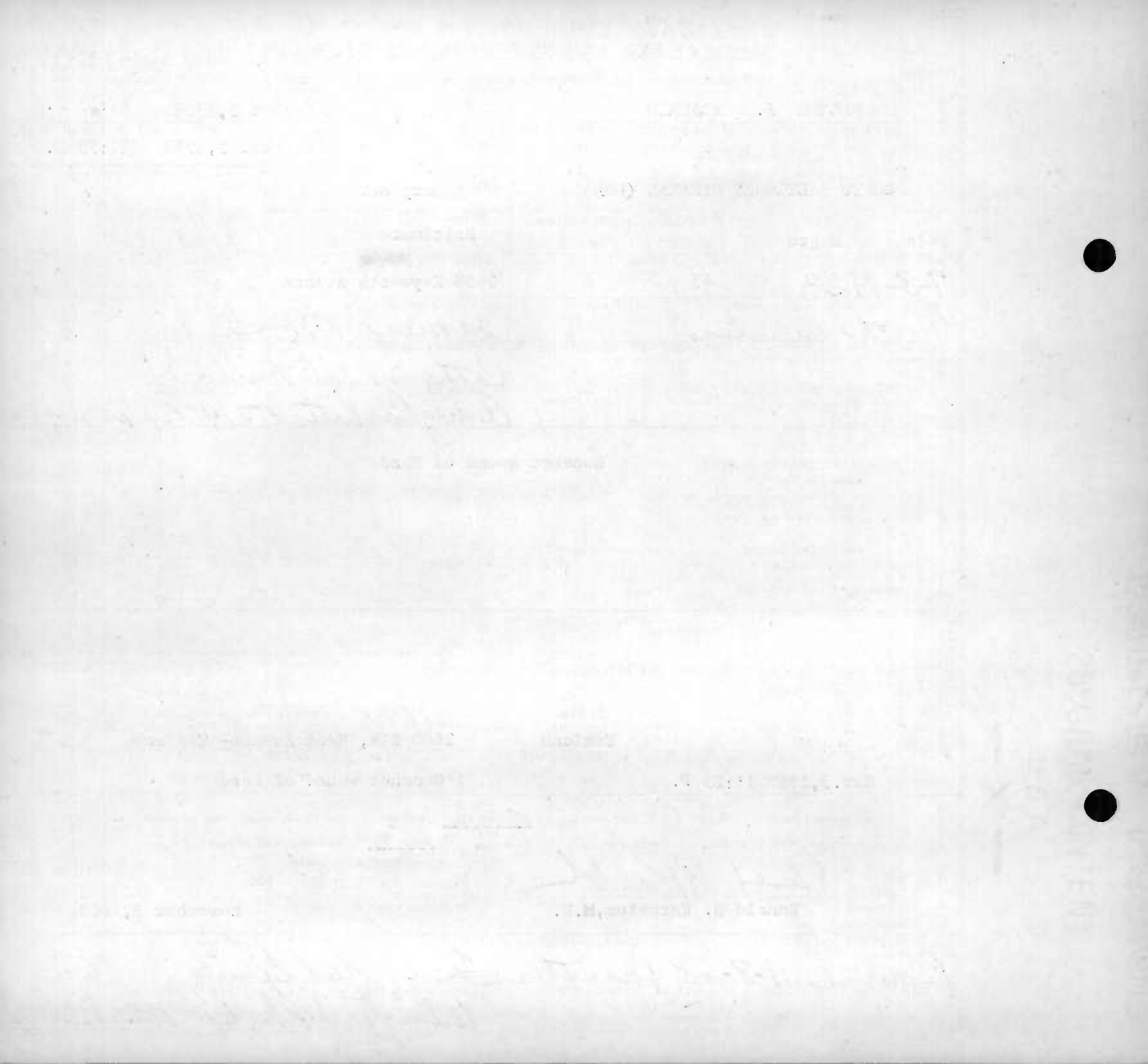
24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

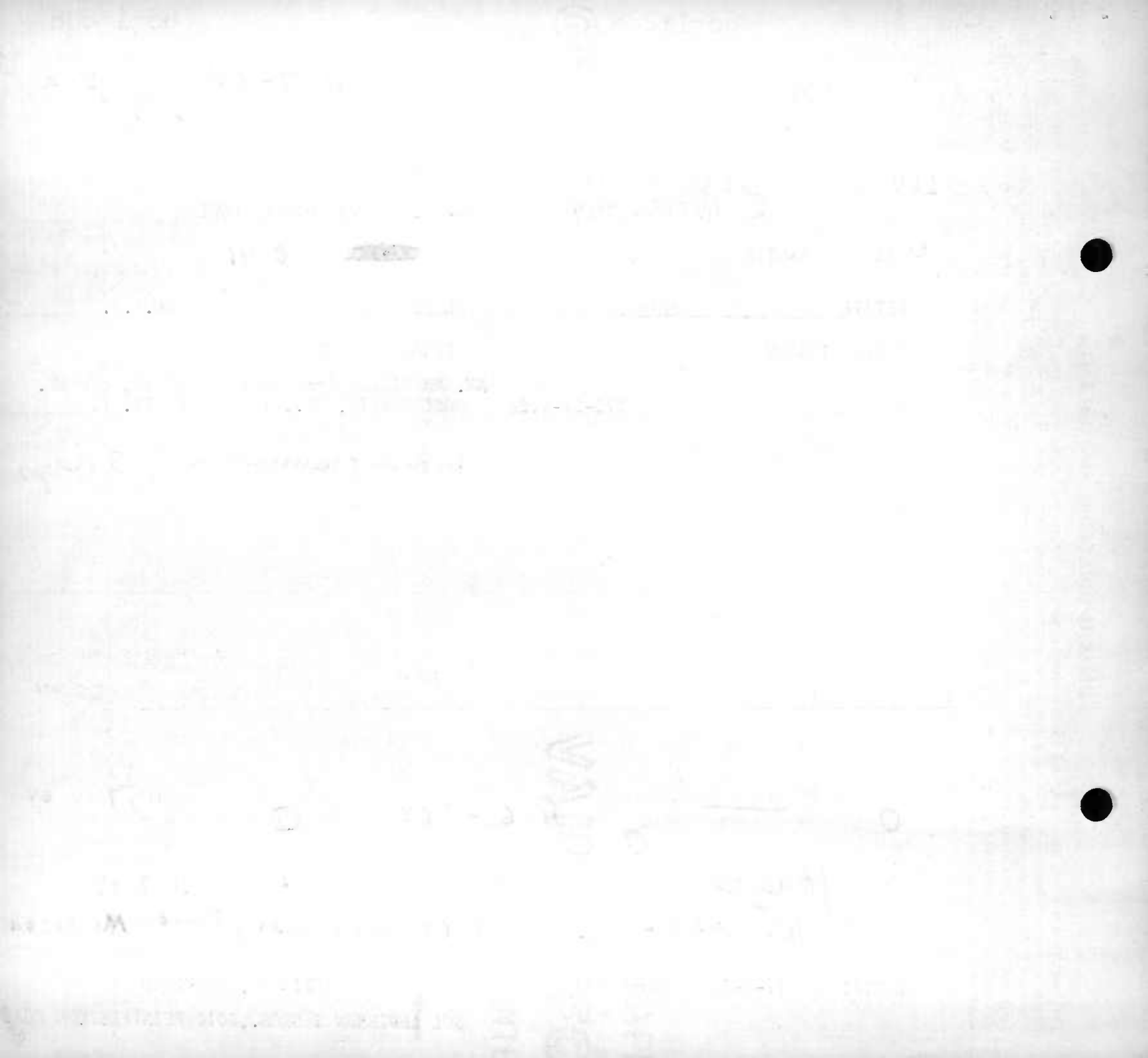
25C. FUNERAL DIRECTOR ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

15 -362		68-11238		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11238	
1. NAME OF DECEASED (Type or Print) <i>Chaim Strasun</i>				2. DATE AND HOUR OF DEATH <i>11-7-68</i> <i>8 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>LEVINDALE HEBREW HOME & INFIRMARY</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>27-17</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>LEVINDALE HEBREW HOME</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>[REDACTED]</i>	9. AGE (In years last birthday) <i>91</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETAIL</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SALESMAN</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GESEL STRASUN</i>				14. MOTHER'S MAIDEN NAME <i>FEGAH ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-54-4226</i>		17. INFORMANT ADDRESS <i>MR. & MRS. HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS, JR., 109 MARKET BL. #2</i>			
18. <i>485 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Bronchopneumonia</i> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <i>3 days</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <i>491 X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11-6-1968</i> to <i>11-7-1968</i> , that (I) (we) last saw the deceased alive on <i>11-6-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>11-7-68</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSE ARDAIZ</i>	
23D. ADDRESS <i>7 OBERLIN COURT, TOWSON, MD 21204</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-8-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>OHEB SHALOM</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11239

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MORTON FOXMAN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

November 6, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 6, 1968

3:20 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1922

10. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3905 Hayward Avenue

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Israel

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wardrobe Dress

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sophie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWII

17. SOCIAL SECURITY NO.

296-10-1998

18. INFORMANT

Harold E. Foxman 5422 Fairbourn Ave

ADDRESS

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 7, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/8/68

24C. NAME OF CEMETERY or CREMATORY

Forest View Vets

24D. LOCATION (City, town, or county)

Rosedale

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 11 1968

25B. NAME OF REGISTRAR

S. S. Lewis

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son, Inc

ADDRESS

Garrison

1947

WALLEY

WALLEY

WALLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

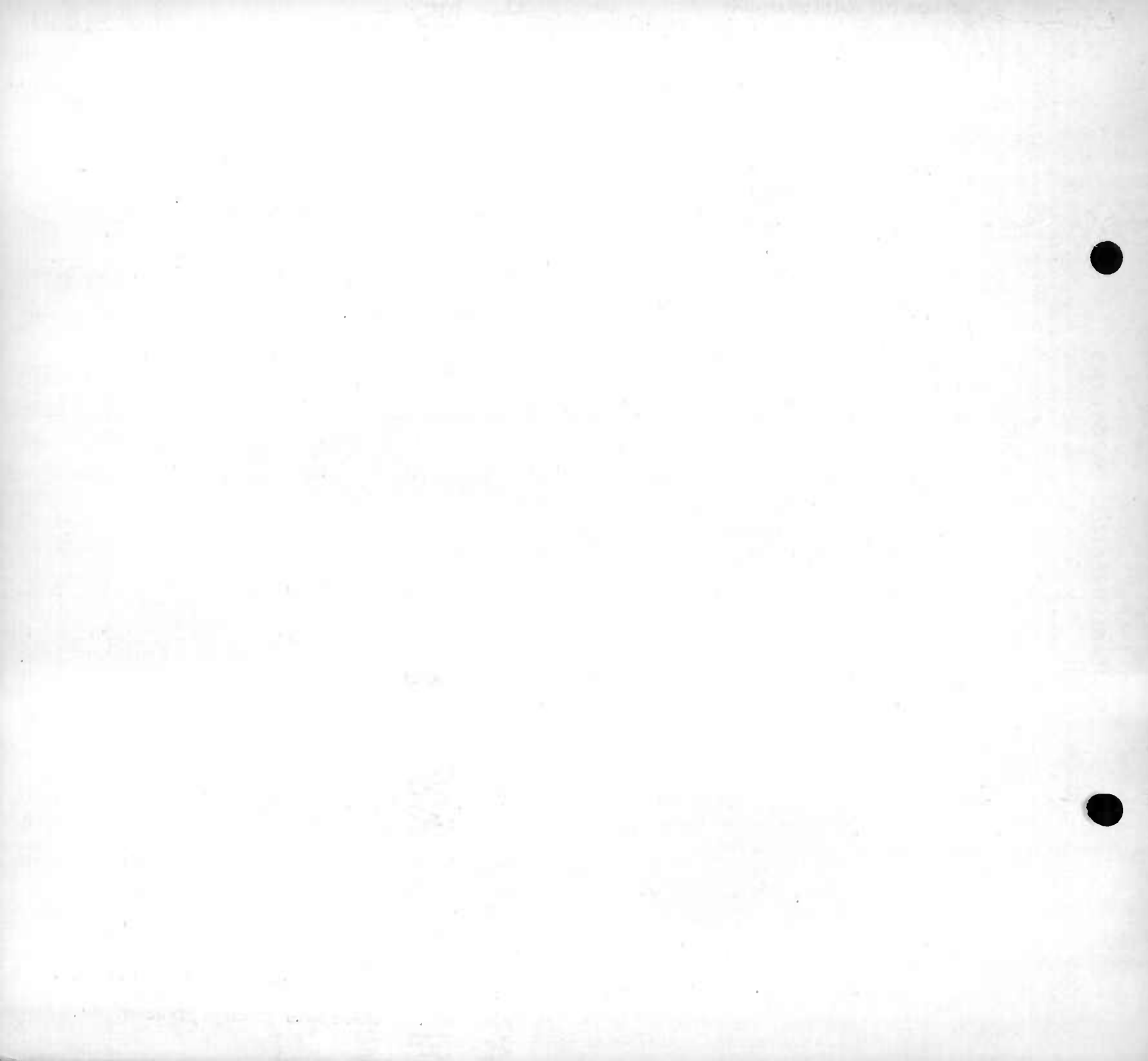
68-11240 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11240

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Glady's M. Lucas</i>		2. DATE AND HOUR OF DEATH <i>11/7/68</i> <i>745</i> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> 8. COUNTY <i>Baltimore</i> <i>53-08</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> <i>Brinden Ave</i> <i>Baltimore Maryland</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		8. DATE OF BIRTH <i>10/3/05</i> 9. AGE (In years lost birthday) <i>63</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Upton S. Muir</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Lakowski</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>179 05 1643</i>		17. INFORMANT <i>Husband</i> ADDRESS	
18. <i>153.8</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic adenocarcinoma of colon</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>May 21 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal Aortic Aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 17</i> 1968 to <i>11/7</i> 1968, that (I) (we) last saw the deceased alive on <i>11/7</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. L. S. Brown, MD</i> OEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>M. L. S. Brown MD</i> OEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 11, 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood</i>	
24D. LOCATION (City, town, or county) (State) <i>Parkwood, Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 11 1968</i>			
25B. NAME OF REGISTRAR <i>2-52, J. J. J.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson, Towson, Md.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

REG. NO. ~~68-11241~~

VS 150-REV. 1/1/6B

ADDRESS
1050 York Rd
Towson
Md.

Luis Enriquez MD UNIV MEDICAL HOSPITAL

Handwritten signature: *Handwritten signature*

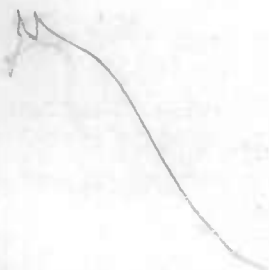
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **68-11242**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM HARROD		2. DATE AND HOUR OF DEATH NOV. 6/68 1 1145 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MD. HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/23/04	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.		9. AGE (In years last birthday) 64 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Chart,		ADDRESS	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST (A) IMMEDIATE CAUSE ELECTROLYTE IMBALANCE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) METASTATIC DISEASE DUE TO, OR AS A CONSEQUENCE OF:		?	
(C) MALIGNANCY				?	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 199.2 II G-I BLOCKING					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 12 19 68 to NOV 6 19 68 , that (I) (was) last saw the deceased alive on NOV 6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Desautels M.D.				23B. DATE SIGNED Nov 6, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNIV. OF MD. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25B. NAME OF REGISTRAR Carroll		25C. FUNERAL DIRECTOR A Halstead 1206 W North Ave			



1
C-200

68-11243 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11243

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DR. W. F. COX, III

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 5508 Kemper Road

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

July 27 1924

10. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm. F. Cox, Jr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katherine Wright

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WW-2

17. SOCIAL SECURITY NO.

212 32 7706

18. INFORMANT

Mrs. Nancy T. Cox-5508 Kemper Rd

ADDRESS

19. 485 X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

Bilateral Bronchopneumonia and

(A) IMMEDIATE CAUSE

~~XXXXXX XXXXXXXXXX~~ Purulent Bronchitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty Alteration of liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/5/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/7/68

24C. NAME of CEMETERY or CREMATORY

Gunpowder Meeting House Cem.

24D. LOCATION (City, town, or county)

Balto. Co.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 11 1968

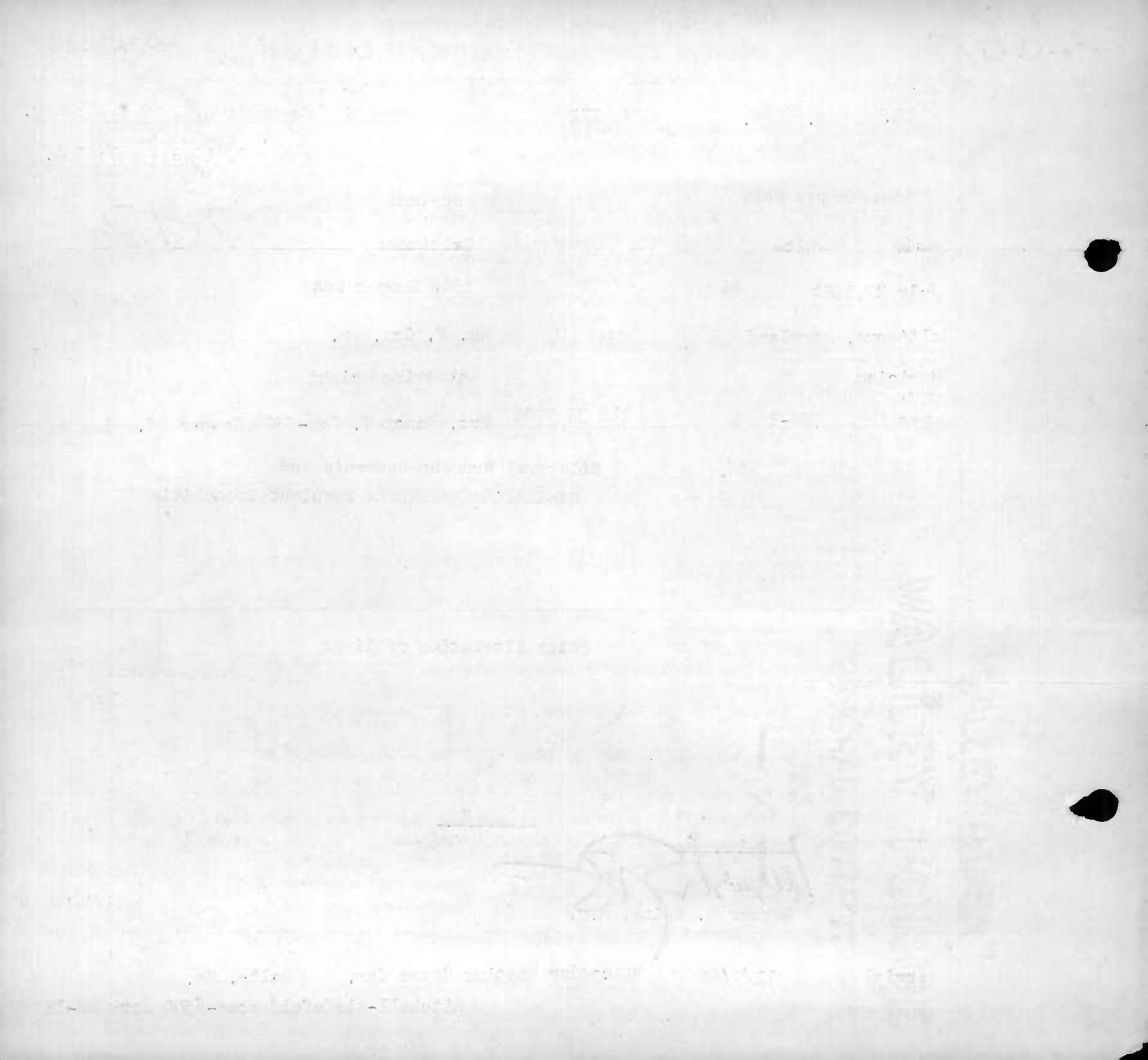
25B. NAME OF REGISTRAR

G. E. S. S. S.

25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home-6500 York Rd-12

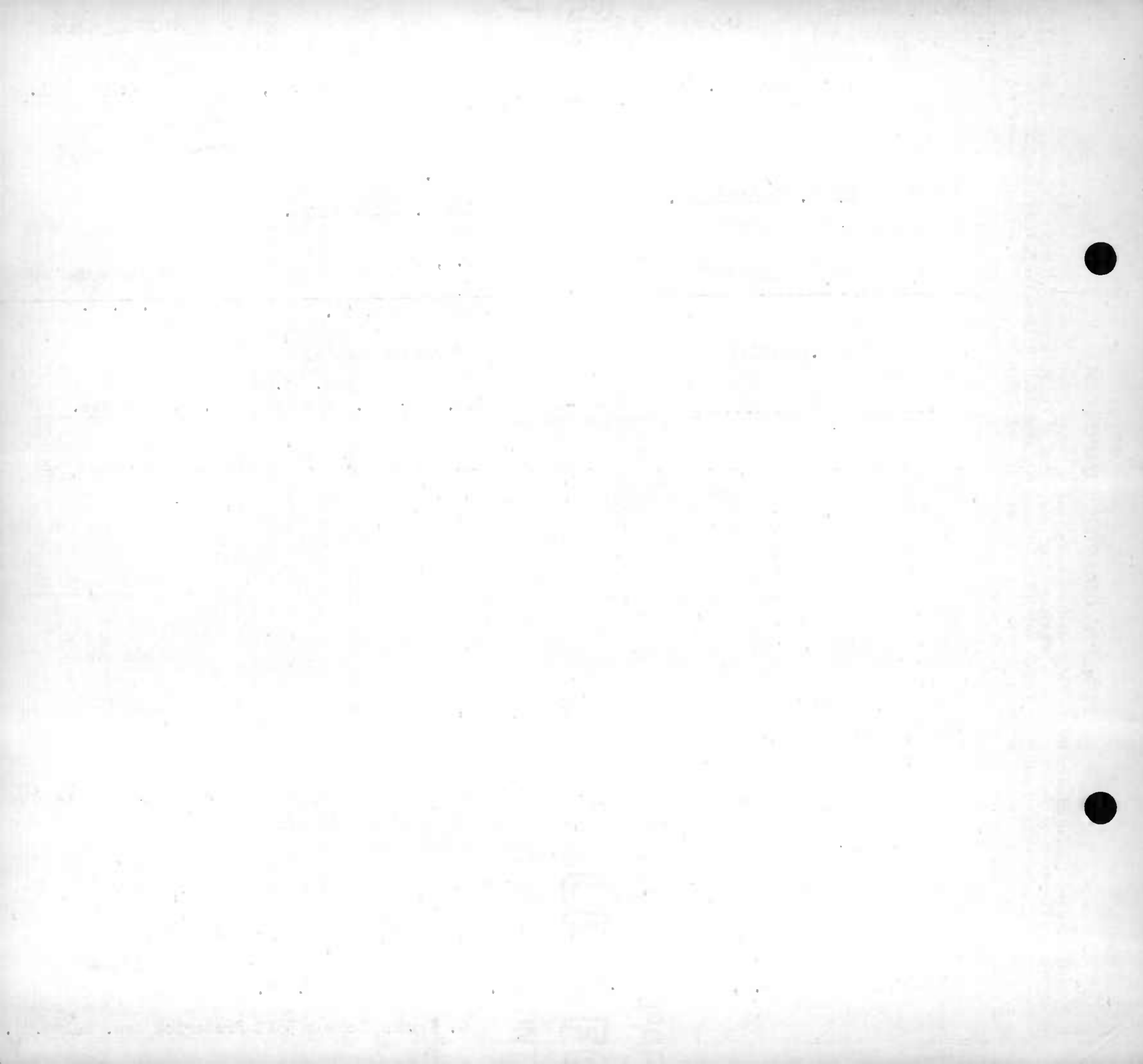
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				REG. NO.	68-11244
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sarah C. Souders		November 6, 1968 4:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 144 S. Collins Ave.			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 144 S. Collins Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1885	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			11. BIRTHPLACE (State or foreign country) Clarksville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John G. Eberling			14. MOTHER'S MAIDEN NAME Margaret Steaver		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-54-1730		17. INFORMANT Balto. Md. 21229 Miss. Alice M. Souders 144 S. Collins Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 412.7 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE A. S. C. V. D. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 30 1968 to Nov 6 1968, that (I) (we) lost saw the deceased alive on Oct 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. POUND				23B. DATE SIGNED 11/8/68	
23C. PHYSICIAN'S NAME (Type) J. C. POUND				23D. ADDRESS 3325 Frederick Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 9, 1968		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25A. NAME OF REGISTRAR G. Truman Schwab		25B. FUNERAL DIRECTOR 3512 Frederick Ave. Balto. Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11245

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HAROLD R. BROWN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

November 7, 1968

6:05 P.

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE

Month

Day

Year

Hour

November 7, 1968

6:05 P.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

June 4-1902

10. AGE (In years
lost birthday)

66

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

818 Wedgewood Road 21229

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William E. Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret. Capt. Fire Dept.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elsie Haines

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-36-8251

18. INFORMANT

ADDRESS

Estell L. Brown 818 Wedgewood Rd. Balto 21229

19. CAUSE OF DEATH

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 8, 1968

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-11-1968

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore City, Baltimore Md.

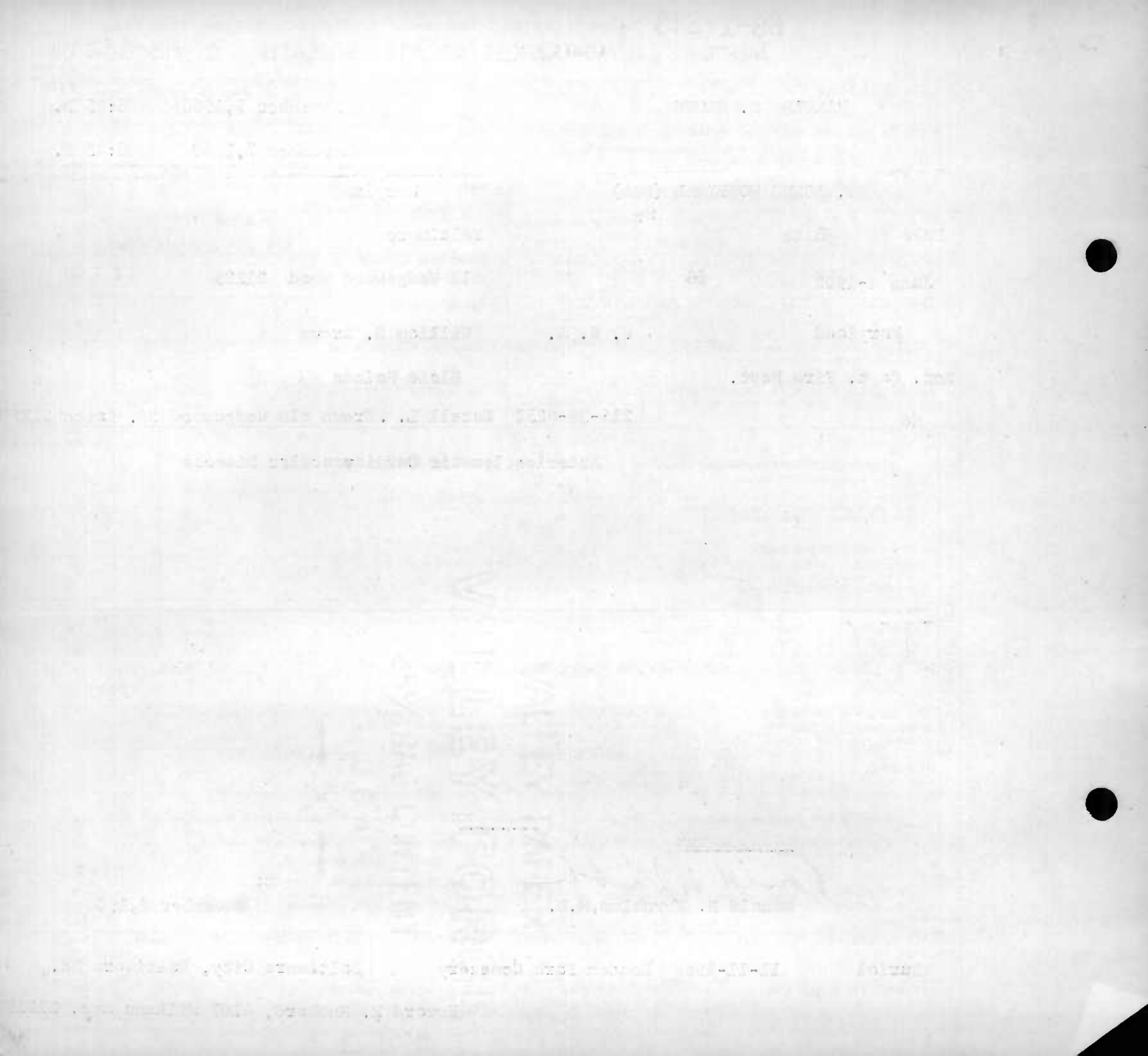
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



1
V-300

68-11246 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11246

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN W. VAETH

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☐ November 7, 1968 2:15 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

MARYLAND GENERAL HOSPITAL

3. DATE
PRONOUNCED DEADMonth Day Year Hour
November 7, 1968 2:15 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore Arbutus

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

11-13-1910

10. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

5234 Benson Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Frank Leopold Vaeth

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Industrial Engineer

14B. KIND OF BUSINESS OR INDUSTRY

Revere Copper & Brass

15. MOTHER'S MAIDEN NAME

Anna Mary Bauer

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-03-3917

18. INFORMANT

Mildred C. Vaeth 5234 Benson Ave. Arbutus

ADDRESS

21227

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 8, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-11-68

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, City, Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229

0.24 0.25 0.26

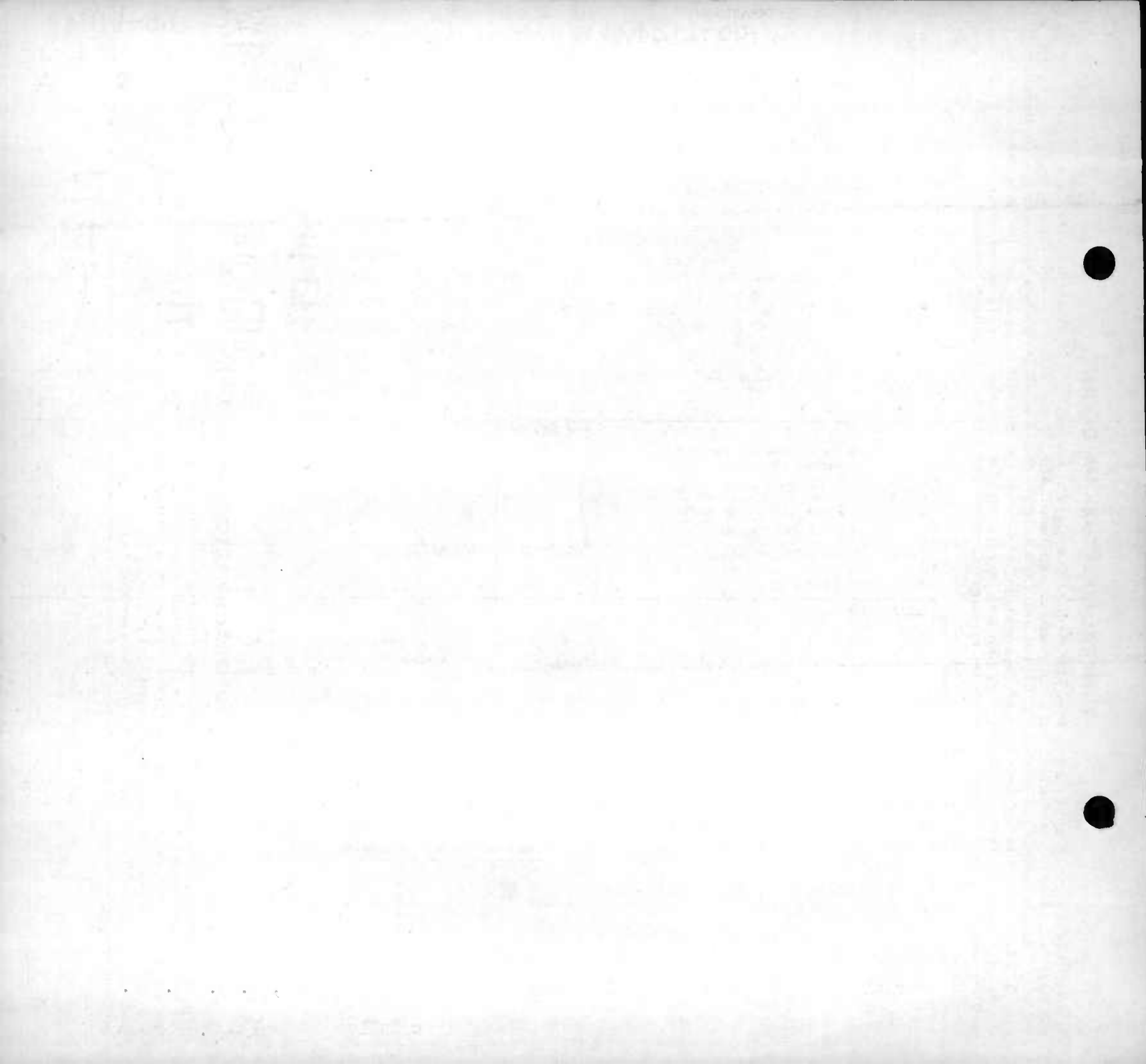
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11247 CERTIFICATE OF DEATH

REG. NO. 68-11247

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LEAR, THOMAS JOSEPH		2. DATE AND HOUR OF DEATH NOV 8, 68 10:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSP. 100 N. CALHOUN ST. BALTO. MD. 21223			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 23-03		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1813 S. CHARLES ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Steam Fitter		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME THOMAS LEAR		
14. MOTHER'S MAIDEN NAME CATHERINE MC MANN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216 109844			17. INFORMANT FRANKLIN SQUARE HOSP.		
18. 123.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 191.0 II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA 17YR. LOWGLIP. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION NOV 1, 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTATIC CARCINOMA		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-29-1968 to NOV 8, 1968 , that (I) (we) last saw the deceased alive on NOV 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sunan VonKasemsiri				23B. DATE SIGNED NOV. 8, 68	
23C. PHYSICIAN'S NAME (Type) SUNAN VONKASEMSIRI				23D. ADDRESS FRANKLIN SQUARE HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 12 68		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25B. NAME OF REGISTRAR Mc Gully		25C. FUNERAL DIRECTOR 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11248		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-11248
BIRTH NO.			1. NAME OF DECEASED (Type or Print) Lee VAUGHN		
2. DATE AND HOUR OF DEATH NOV. 8, 1968			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY of Maryland		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 15-D1			5. CITY OR TOWN BALTIMORE		
6. STREET AND NUMBER CADEN + Lombard STS 207 N. Amity St			7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. SEX M	9. RACE C	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 5/7/1900	12. AGE (In years lost birthday) 68	13. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			15. KIND OF BUSINESS OR INDUSTRY		
16. FATHER'S NAME Richard VAUGHN			17. MOTHER'S MAIDEN NAME Frankie Pyle		
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			19. SOCIAL SECURITY NO. 218-05-0742		
20. INFORMANT Lottie Vaughan			21. ADDRESS 207 N. Amity St.		
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91			23. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC Arrest (B) MYOCARDIAL Infarction (C) Anteroseptal myocardial infarction		
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II			25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pseudomonas Urinary Tract Infection		
26. DATE OF OPERATION 0 -		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? (Yes or No) NO	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
32. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
35. I certify that (1) (this hospital) attended the deceased from Nov. 3, 1968 to Nov. 8, 1968 , that (1) (we) last saw the deceased alive on Nov. 8, 1968 and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
36. SIGNATURE G.M. Lattin M.D.			37. DATE SIGNED Nov. 8, 1968		
38. PHYSICIAN'S NAME (Type) GARY M. LATTIN M.D.			39. ADDRESS University Hospital MD.		
40. BURIAL CREMATION, REMOVAL (Specify) Burial		41. DATE 11/10/68		42. NAME of CEMETERY or CREMATORY St. Albans Cem.	
43. DATE RECD BY HEALTH DEPT.		44. NAME OF REGISTRAR		45. FUNERAL DIRECTOR Williams Funeral Home	
46. ADDRESS		47. ADDRESS 3199 Schowder St.			

6
10

UNIVERSITY of Maryland

INSTITUTE

X

GREEN - LAMONT STATION

✓

M C

2/7/77

LABORER

Virginia

RECENT VANDAL

FRANCIS HYLE

UNKNOWN

CARDINAL ARREST

MYOCARDIAL INFARCTION

PERICARDIUM (Heart) TISSUE

Nov 7

○

Nov 8

○

Nov 8

○

○

○

○

MR. KATZ M.D.

X

Memorial Hospital

GARY A. LATTIN M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. F-624				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11249
1. NAME OF DECEASED (Type or Print) JOHN FOEHRKOLB			2. DATE AND HOUR OF DEATH 11-6-68 5:40 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 11-18-68			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 405 ESSEX AVENUE 21221			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1895		9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN			14. MOTHER'S MAIDEN NAME ANN KAGLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 717-07-5467		17. INFORMANT BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.		
18. 303.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Hepato-Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Alcoholism Septicemia DUE TO, OR AS A CONSEQUENCE OF: (C) Prostatic Hypertrophy			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 322.2 II						
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-1 19 68 to 11-6 19 68 , that (I) (we) last saw the deceased alive on 11-6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE B.D. Richman M.D.				23B. DATE SIGNED 11/6/68		23C. PHYSICIAN'S NAME (Type) B.D. RICHMAN M.D.
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) (State) BALTO. MD.		
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR J. G. CORNELLY SONS		25C. FUNERAL DIRECTOR ADDRESS 300 NACE		

68-11250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11250

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LONNIE E. MYERS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968		Hour 10:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968		Hour 10:45 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore				53-0			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore Colgate	
9. DATE OF BIRTH 9-4-50.		10. AGE (In years lost birthday) 18		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Tunnelton, W. Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 7501 Cypress Avenue . Balto., 21224, Md.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY Crown, Cork and Seal		15. MOTHER'S MAIDEN NAME Gloria G. Funk	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 217-54-1789		18. INFORMANT ADDRESS Gloria G. Myers 7501 Cypress Ave. # 21224.	
19. E 965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Head				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Auto			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Penna Ave. and Lafayette				14-02			
22D. TIME OF INJURY (APPROX.) Nov. 8, 1968 8:30 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Gunshot wound to head							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED November 9, 1968 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-12-68.		24C. NAME of CEMETERY or CREMATORY Mt. Zion Cemetery		24D. LOCATION (City, town, or county) (State) Tunnelton, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Charles S. Zeiler		25C. FUNERAL DIRECTOR 6224 Eastern Ave. Balto., 21224, Md.			

VALLEY FORCE

75/474-2111

11-11-11

11-11-11

11-11-11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11251 CERTIFICATE OF DEATH

REG. NO. 68-11251

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JULIAA. AVESSER

2. DATE AND HOUR OF DEATH

11-4-68, 400am

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

36 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3226 O'DONNELL ST (24)

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-16-93

9. AGE (In years
last birthday)

75

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

AMER.

13. FATHER'S NAME

WILLIAM D. BROWN

14. MOTHER'S MAIDEN NAME

MARY M. HUMMELL

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-19-2576

17. INFORMANT

WILLIAM A. AVESSER

ADDRESS

SAME

18. 431.01

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Hypertension, Renal insufficiency

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(X)~~ (this hospital) attended the deceased from 11-2-1968 to 11-4-1968,
that ~~(X)~~ (we) last saw the deceased alive on 11-4-1968 and that in ~~(X)~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~(X)~~ (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Nidiry

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

JOSEPH NIDIRY

23D. ADDRESS

CHURCH HOME AND HOSPITAL

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-7-68

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN CEM.

24D. LOCATION

(City, town, or county)

7225 EASTERN BLVD, BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

NOV 12 1968

25B. NAME OF REGISTRAR

Charles J. Seiler

25C. FUNERAL DIRECTOR

Charles J. Seiler

ADDRESS

901 S. CONKLING ST. BALTO., 21224, MD.

CHURCH OF THE HOLY TRINITY

W. C. F. C.

W. C. F. C.

W. C. F. C.

W. C. F. C.

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W. C. F. C.

W. C. F. C.

W. C. F. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11252 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 68-11252

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harvey C. Green		11-5-68 1:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc.		A. STATE Maryland		B. COUNTY	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2332 McCulloh Street		13-03	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-86	9. AGE (In years lost birthdate) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) R.R. Penn. (Retired)		10B. KIND OF BUSINESS OR INDUSTRY Baggage Penn.RR		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Mitchell Green		14. MOTHER'S MAIDEN NAME Mary Perry		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-7503		17. INFORMANT Mrs. Esther Green-wife	
				ADDRESS SAME	
18. 412-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD & congestive heart failure, severe (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 420.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 7, 1968 to November 5, 1968, that (I) (we) lost saw the deceased alive on November 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. J. H. SAUNDERS		23B. DATE SIGNED 11-8-68			
23C. PHYSICIAN'S NAME (Type) E. J. H. SAUNDERS		23D. ADDRESS 3414 Euclid Ave. Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
				24D. LOCATION (City, town, or county) (State) Anne Arundle Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11253

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jesse Thomas Vaughn		Nov. 2, 1968 8:12 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md.	
US Public Health Service Hospital 3100 Wyman Pk. Drive				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 807 N. Bentalou St.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> (Sep) DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	Col		5/1/30	38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Shipping Clerk		Leon Levi		NC, Conway	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Will Vaughn			Sudie Flight		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		USMC 1953-1956		Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				days	
Cardiorespiratory failure secondary to probable septic shock					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Menigitis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct. 30 19 68 to Nov. 2 19 68, that (I) (we) last saw the deceased alive on Nov. 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Norman H. Peckham, M.D.				11/4/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Norman H. Peckham, M.D.		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11/6/68	Baltimore National Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
Nov 11 1968		Herbert E. Nutter		Herbert E. Nutter-3035 W. North Ave.	

1881

W. H. P. H. 1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11254 CERTIFICATE OF DEATH

REG. NO. 68-1263
68-11254

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Phillips, Julia F</u>		2. DATE AND HOUR OF DEATH <u>Nov. 4 '68</u> <u>4, 30 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Harford</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		8. DATE OF BIRTH <u>9-14-98</u> 9. AGE (In years last birthday) <u>70</u>	
11. BIRTHPLACE (State or foreign country) <u>Md, Arbutus</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Jausha B. Williams Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Frances A. Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter E. Phillips</u> ADDRESS <u>1107 Sulphur Spring Rd.</u>	
18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>metastatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>	
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>May 1968</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>not improved</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>sep. 1</u> 19 <u>68</u> to <u>Nov. 4</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>NOV. 4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>NOV. 4 '68</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Harold Johnson</u>	
23D. ADDRESS <u>Lutheran Hospital of Maryland</u>		24A. BURIAL CREATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>11/7/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Star Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 11 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u> ADDRESS <u>3035 W. North Ave.</u>	

Western Hospital of Maryland Maryland
Female 11 8-14-98 40

Walter Hesp

Calverton

metastatic cancer

noted on 11-14-98

Nov. 4 1908 00

Walter Hesp

Western Hospital of Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

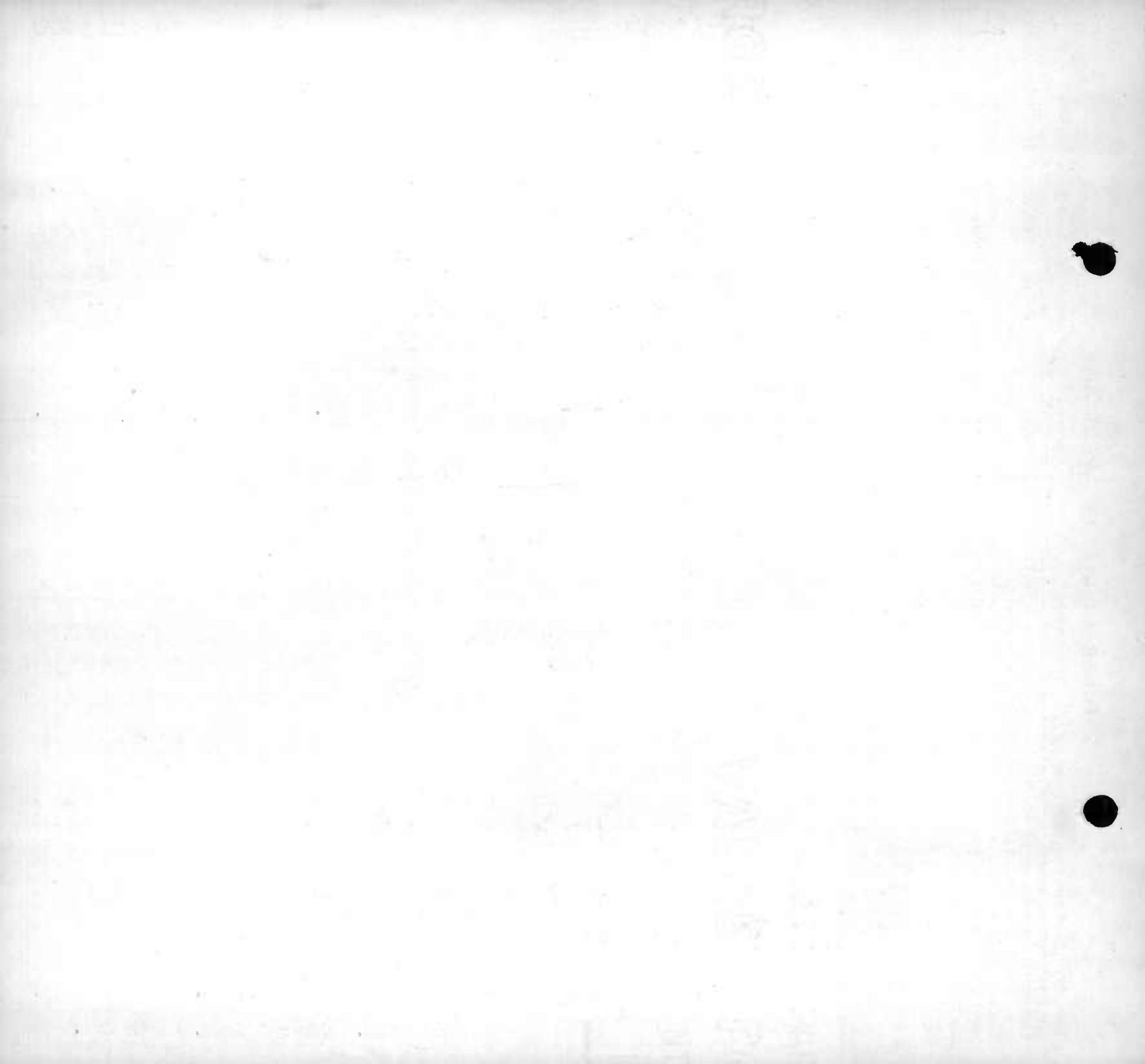
68-11255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11255

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James Williams (Robert)</u>		2. DATE AND HOUR OF DEATH <u>Nov. 3 1968</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE-CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>611 Cherrycrest Rd. #25</u>			
5. SEX <u>m</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-15</u>	9. AGE (In years last birthday) <u>53</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Merchants Terminal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Barnes</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-12-0912</u>		17. INFORMANT <u>Mrs Marjorie C. Williams</u> ADDRESS <u>611 C. Cherrycrest Rd.</u>	
18. <u>410.91x202.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>420.1 II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> (B) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Lymphoma</u>		19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Lymphoma</u>	
19C. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> 19 <u>68</u> to <u>11-3</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>San Lo Baeuer MD</u>		23B. DATE SIGNED <u>11-5-68</u>			
23C. PHYSICIAN'S NAME (Type) <u>San Lo Baeuer MD</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/7/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 11 1968</u>		25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>	
25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u>		25D. ADDRESS <u>3035 W. North Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11256
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALVIN DOUGLAS JONES		2. DATE AND HOUR OF DEATH NOV 3, 68 12 30 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 425 N. W. HOSPITAL OF BALTIMORE INC		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2704 GARRISON BLVD		
5. SEX M	6. RACE N N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/28/27	9. AGE (In years last birthday) 41 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Cook		10B. KIND OF BUSINESS OR INDUSTRY Ship		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alvin Jones Sr.		
14. MOTHER'S MAIDEN NAME Gladys Spencer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) Yes 6/1/53 5/1155		
16. SOCIAL SECURITY NO. 214-20-8 870		17. INFORMANT Mrs Dorothy Mcutheon 2704 Garrison Blvd.		
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC TAMPONADE (B) PERICARDITIS DUE TO, OR AS A CONSEQUENCE OF: (C) Acute bilat. PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 24 hrs. 72 hrs.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 490X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 2, 19 68 to NOV. 3 19 68 , that (I) (we) last saw the deceased alive on NOV 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Lauentman MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JAIME LAUENTMAN MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		
25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave.		

THE HOSPITAL OF BALTIMORE
JAN 10 1914
H
H

(REG-10 THERAPY)

PERICARDITIS
Acute but PNEUMONIA

NOVEMBER 22 1913
JAN 2 1914

JOHN LAURENCE
MD
J. J. LAURENCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

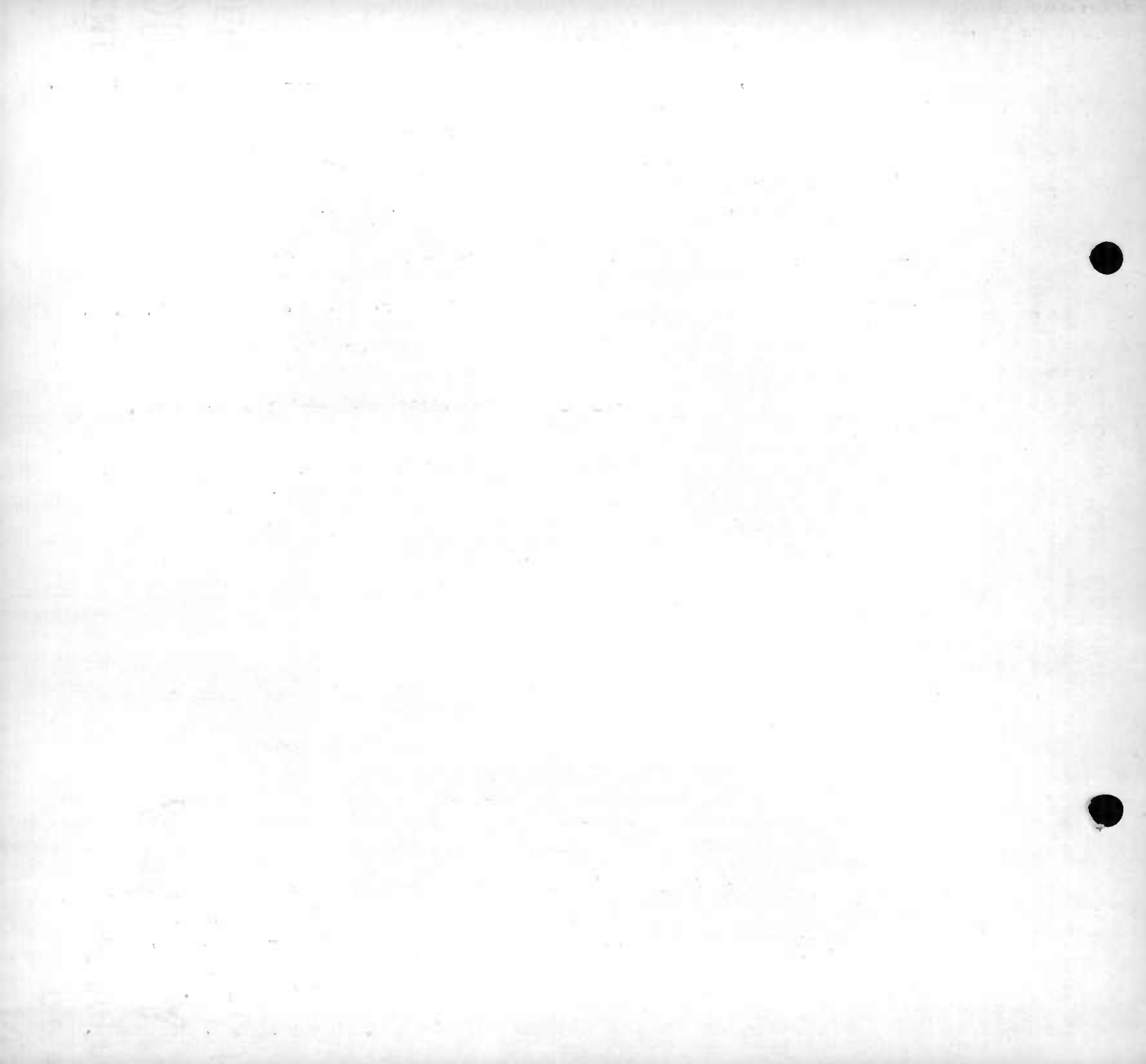
68-11257

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11257

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hawkins, Lena (Sampson)		11-3-68 12:20 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 39				A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Division Street Baltimore, Maryland				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 512 McMechen Street.					
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-08	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saint Mary CO. MD.	
13. FATHER'S NAME Henry Shirley				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. MOTHER'S MAIDEN NAME Emmaline Brooks					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-44-1122		17. INFORMANT Mrs Lillian Spencer 1711 Brunt St.	
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 490 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumococcal Meningitis</i> (B) <i>Pneumonia, Bilateral</i> (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-30-68 19 to 11-3-68 19, that (I) (we) last saw the deceased alive on 11-3-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gregorio S. Teneco M.D.</i>				23B. DATE SIGNED 11-4-68	
23C. PHYSICIAN'S NAME (Type) GREGORIO S. TENECO				23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/68		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery	
24D. LOCATION Baltimore, MD.					
25A. DATE REC'D BY HEALTH DEPT. 2-1-69		25B. NAME OF REGISTRAR <i>Gregorio S. Teneco</i>		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11258

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) SOMMERFIELD HENSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 7, 1968 5:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 7, 1968 5:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? 15 - YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 18 July 1896		10. AGE (In years last birthday) 72 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Eastern Shore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morgan Henson		14. MOTHER'S MAIDEN NAME Ella Green	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-30-3978A	
18. INFORMANT Mrs. Maybell Henson		ADDRESS 1804 N. Carey Street	
19. CAUSE OF DEATH E 814.17 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: E 812.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? North Avenue near Retreat Street		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Nov. 7, 1968 5:05 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED November 8, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 12 1968	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	

1. The first part of the document is a letter from the President of the United States to the Congress.

2. The second part is a report from the Secretary of the Treasury on the state of the Union.

3. The third part is a report from the Secretary of the Navy on the state of the Navy.

4. The fourth part is a report from the Secretary of the War on the state of the War.

5. The fifth part is a report from the Secretary of the Interior on the state of the Interior.

6. The sixth part is a report from the Secretary of the Agriculture on the state of the Agriculture.

7. The seventh part is a report from the Secretary of the Commerce on the state of the Commerce.

8. The eighth part is a report from the Secretary of the Education on the state of the Education.

9. The ninth part is a report from the Secretary of the Health on the state of the Health.

10. The tenth part is a report from the Secretary of the Labor on the state of the Labor.

11. The eleventh part is a report from the Secretary of the Finance on the state of the Finance.

12. The twelfth part is a report from the Secretary of the Justice on the state of the Justice.

13. The thirteenth part is a report from the Secretary of the State on the state of the State.

14. The fourteenth part is a report from the Secretary of the War on the state of the War.

15. The fifteenth part is a report from the Secretary of the Navy on the state of the Navy.

16. The sixteenth part is a report from the Secretary of the Interior on the state of the Interior.

17. The seventeenth part is a report from the Secretary of the Agriculture on the state of the Agriculture.

18. The eighteenth part is a report from the Secretary of the Commerce on the state of the Commerce.

19. The nineteenth part is a report from the Secretary of the Education on the state of the Education.

20. The twentieth part is a report from the Secretary of the Health on the state of the Health.

21. The twenty-first part is a report from the Secretary of the Labor on the state of the Labor.

22. The twenty-second part is a report from the Secretary of the Finance on the state of the Finance.

23. The twenty-third part is a report from the Secretary of the Justice on the state of the Justice.

24. The twenty-fourth part is a report from the Secretary of the State on the state of the State.

B-650

68-11259 BALTIMORE CITY HEALTH DEPARTMENT

68-11259

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TAYLOR BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 6, 1968		Hour 6:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 131 N. Wolfe Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 6, 1968		Hour 6:20 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4-23-1904		10. AGE (In years last birthday) 64	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 131 N. Wolfe Street		
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SIM BROWN			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME BARBARA ANN			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 217-03-1346		18. INFORMANT HELEN BROWN		ADDRESS 1825 N. BROADWAY	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease		CAUSE OF DEATH Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:		(E) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 443X II		20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 6, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-12-68		24C. NAME OF CEMETERY or CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR R. S. 2. Johnson		25C. FUNERAL DIRECTOR JOSEPH KNIGHT		ADDRESS 1639 N. BROADWAY	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) THEODORE R. ROBINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> October 28, 1968 6:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 811 S. Fremont (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour October 29, 1968 9:50 A.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/11/1902 64		10. AGE (In years last birthday) 66 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) va		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Gertrude Brown 64yr Mother		ADDRESS	
19. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 10/29/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE II-4-68	
24C. NAME of CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) A.A.CO., Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Isaiah L. Brown and Son	
25C. FUNERAL DIRECTOR 108 W. Montgomery Street		ADDRESS	



WALL BERRY P. B. 1913
VOLLEY 1913
HARRIS 1913

FUNERAL DIRECTOR: IMPORTANT

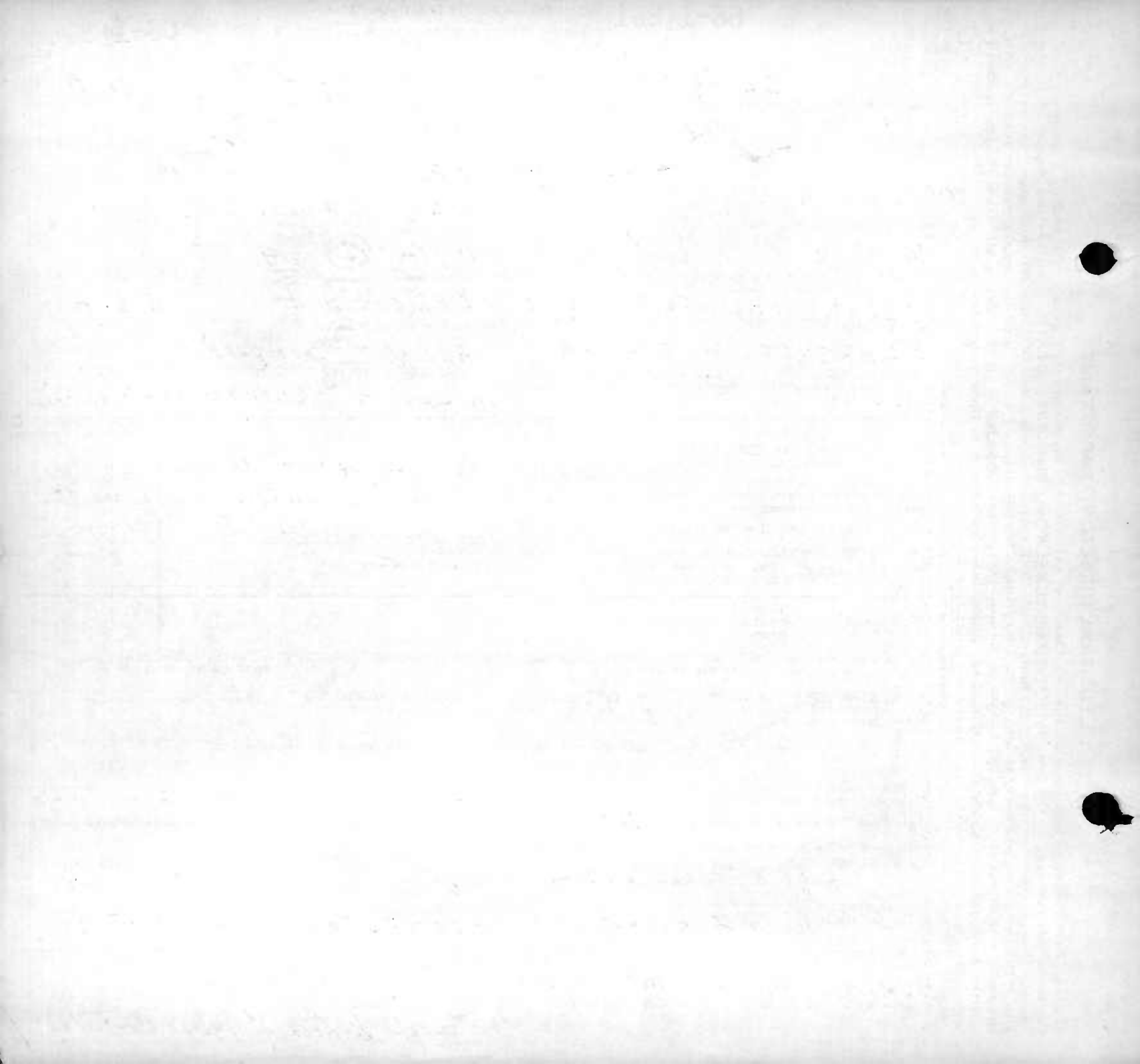
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11261

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Clifford C. Howard		11-6-68 11 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE-CITY LIMITS?	
009049 N. CAROLINE ST				BALTO. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1049 N. CAROLINE S	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	C.		11/14/98	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CLERK (R)		Post Office		BALTO., Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CLARENCE G. HOWARD			ANNIE SIMPSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MARY H. KENNERD 1049 N. CAROLINE ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C.V. disease - marked decomposition - (B) Permeous Anemia; Sclerotic - (C) ... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs - 6 months - 40 yrs -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1927 to 11-2-1968, that (I) (we) last saw the deceased alive on 11-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph N. Zierler M.D.				23B. DATE SIGNED 11-8-68	
23C. PHYSICIAN'S NAME (Type) Jos. N. Zierler				23D. ADDRESS 2502 Eutaw Place - Balto - Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		11/9/68		mt. Auburn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
BALTO. Md.		Joseph N. Zierler 1304 N. Central Ave			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 11 1968		Joseph N. Zierler		Joseph N. Zierler	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALLEN E. MUSE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 6, 1968 Hour 10:05 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 413 E. Biddle Street (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour November 6, 1968 10:05 A.M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 68		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1001	
11. BIRTHPLACE (State or foreign country) va		12. CITIZEN OF WHAT COUNTRY?		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction		E. STREET AND NUMBER 413 E. Biddle Street	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-09-8457		15. MOTHER'S MAIDEN NAME SIDNEY WILLIAMS	
19. 185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Carcinoma of Prostate with Metastases (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		ADDRESS Manuel Maria 413 E. Biddle St APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 6, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY mt. Calvary	
24D. LOCATION (City, town, or county) (State) Q. D. County - Md		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Joseph E. Locks Jr	
25C. FUNERAL DIRECTOR 1304 N. Central St		ADDRESS			

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WATKINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11263
BIRTH NO. 516		68-11263		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <i>Albert C. Gamber</i>		2. DATE AND HOUR OF DEATH <i>11-6-68 3:20 p. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>1307 W. Northern Pkwy.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>27-38</i>		
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4-5-05</i>		9. AGE (In years last birthday) <i>63.</i>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cashier</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>HALLMAN</i>		
14. MOTHER'S MAIDEN NAME <i>Lillian ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>283-09-0744</i>		17. INFORMANT <i>Family - Same</i>		
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary occlusion</i> (B) <i>Coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>unknown</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 13</i> 19 <i>55</i> to <i>Nov. 6</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Oct. 24</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Abraham B. Hurwitz</i>		23B. DATE SIGNED <i>Nov. 8, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>ABRAHAM B. HURWITZ, M.D.</i>
23D. ADDRESS <i>7501 Liberty Rd., Baltimore, Md.</i>		23E. FUNERAL DIRECTOR <i>McElroy Funeral Homes</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>11/01/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>
24D. LOCATION <i>Baltimore</i>		24E. DATE REC'D BY HEALTH DEPT. <i>NOV 11 1968</i>		
24F. NAME OF REGISTRAR <i>028 62858</i>		24G. ADDRESS <i>2401 E. Baltimore Ave.</i>		

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11264

VS 150-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11265

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BROOKS, MATTIE B.

2. DATE AND HOUR OF DEATH

11/7/68

9:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

COCKEYSVILLE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

35 SHERWOOD ROAD

5. SEX

F

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11-15-91

9. AGE (In years lost birthday)

76

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

AMERICAN.

13. FATHER'S NAME

BENJAMIN R. BENSON.

14. MOTHER'S MAIDEN NAME

MARY A. ARNALCOST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-14-6337

17. INFORMANT

Paul Brooks

ADDRESS

42 Sherwood Rd. Cockeysville, Md.

18.

427.21

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE RUMORARY EDEMA. CHF. DUE TO, OR AS A CONSEQUENCE OF:

(B) CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF:

(C)

433.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from

11-06

19 68 to

11/7

19 68.

that (I) last saw the deceased alive on

11/7

19 68

and that in (my) opinion death occurred on the date

and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Luis E. INTADO M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/7/68

23C. PHYSICIAN'S NAME (Type)

Luis E. INTADO M.D.

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-9-1968

24C. NAME OF CEMETERY OR CREMATORY

Jessop Cemetery

24D. LOCATION

Sparks, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson

ADDRESS

1050 York Rd. Towson, Md.

1079
UNION MEMORIAL HOSPITAL 25 SOVEREIGN ROAD
COCKEYSVILLE

11-18-21 26

MARY A ARMISTEAD
MAY 1 1922

BENTAMIN A BERTON
MAY 1 1922

SPRINGFIELD CH

CARROLL ARREST

Yes

11-18-21 26

11/18/21
L. J. BENTON
L. J. BENTON

UNION MEMORIAL HOSPITAL

NONX MED Dr. Spitz ~~XXXXXX~~ ~~XXXXXX~~
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Not a Medical Examiner's Office per Dr. Spitz
MEDICAL CERTIFICATION

BIRTH NO. 68-11266		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11266	
M.E. CASE NO.			1. NAME OF DECEASED <i>MARGARET A CROUSE</i>		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH <i>11/5/68 12:08 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE <i>MARYLAND</i> B. COUNTY <i>QUEEN ANNES 67-00</i>		
<i>33 THE JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>2-18-09</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Edward Higdon</i>			14. MOTHER'S MAIDEN NAME <i>Wilhelmina Tarbutton</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-26-2221</i>	17. INFORMANT <i>Husband</i> ADDRESS <i>HARRY G. CROUSE, GRASONVILLE, MD</i>		
18. <i>441.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH <i>Dissecting Aortic Aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>451X II</i>					
19A. DATE OF OPERATION <i>3 11/5/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Dissecting Aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/4/68</i> 19 <i>68</i> to <i>11/5</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Howard C Swider, Jr.</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>11/5/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>HOWARD C SWIDER, JR.</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>Nov. 9, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ridgely Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Ridgely, Caroline Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 11 1968</i>		25B. NAME OF REGISTRAR <i>John G. Swider</i>		25C. FUNERAL DIRECTOR ADDRESS <i>BARTON BROS, CENTREVILLE, MD, 24617</i>	

14 28 9

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11/2/68

11/2/68

11/2/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11267
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		BLEVINS, VILLANA ADA		NOVEMBER 8, 1968 7:59 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
		A. STATE B. COUNTY		
		MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
ST AGNES HOSPITAL CATON & WILKENS AVE BALTO MD 21229		GLEN BURNIE		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER		
		18 NEW JERSEY AVE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	08 08 1921	47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
HOUSEWIFE		Own Home		MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
CHARLES DIETZ		MARY () Wacker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO				ST AGNES RECORDS-CATON & WILKENS AVE
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMATOSIS TERMINAL STAGE				
(B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O		NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that XX (this hospital) attended the deceased from OCT. 25 19 68 to NOV. 8 19 68, that IX (we) last saw the deceased alive on NOV. 8 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.				
23A. SIGNATURE			23B. DATE SIGNED	
Marino M. Cabiling			11 08 68	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS	
MARINO CABILING			ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	11 Nov. 68	Glen Haven Memorial Park	Glen Burnie, AA Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
NOV 11 1968	Glen Burnie, Md.	Kirkley Funeral Home, Glen Burnie, Md.		

17

1881

On line

Index

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Film 0525, 11/15/78

BALTIMORE CITY HEALTH DEPARTMENT

68-11268 CERTIFICATE OF DEATH

REG. NO. 68-11268

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KOOTSIKAS, GEORGE NICKOLAS

2. DATE AND HOUR OF DEATH

NOVEMBER 7, 1968

6:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST AGNES HOSPITAL
CATON & WILKENS AVE
BALTO MD 21229

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3570 S HANOVER STREET

21225

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

09 15 85

9. AGE (In years last birthday)

83

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RESTAURANT OWNER

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

GREECE

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

NICK KOOTSIKAS

14. MOTHER'S MAIDEN NAME

IANNPOLOS

CONSTANTINA F

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216329693

17. INFORMANT

ADDRESS

ST AGNES RECORDS-CATON & WILKENS AVE

18. 431.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Intra-Cerebral Hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

331X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

None

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X (this hospital) attended the deceased from NOV. 7 19 68 to NOV. 7 19 68, that X (we) last saw the deceased alive on NOV. 7 19 68 and that in X (my) (our) opinion death occurred on the date and hour and from the causes stated above X (We) (did) (did not) view the body after death.

23A. SIGNATURE

Morton Blumberg

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/7/68

23C. PHYSICIAN'S NAME (Type)

MORTON BLUMBERG

DEGREE

23D. ADDRESS

ST AGNES HOSP. BALTO MD 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/11/68

24C. NAME of CEMETERY or CREMATORY

Greek Orthodox Cemetery

24D. LOCATION

Woodlawn Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 11 1968

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

McAdams

ADDRESS

237 Patapsco Ave. 21225

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

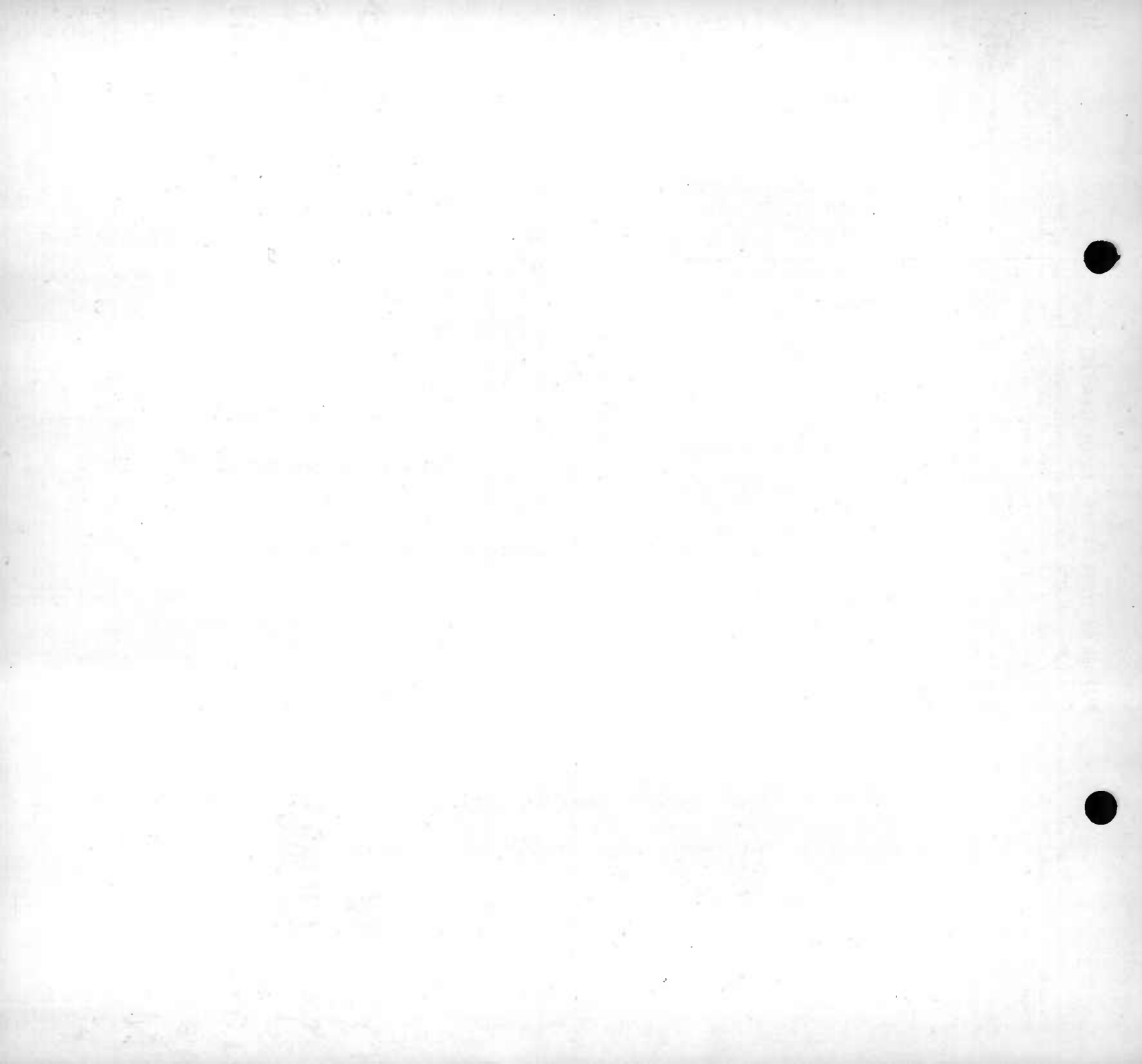
68-11269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11269

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary Rosetta Gross <i>LEWIS</i>		2. DATE AND HOUR OF DEATH Nov. 4, 1968 2:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Pk. Drive			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-56 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2868 W. Lanvale St.		
5. SEX F	6. RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/09	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME John L. Lewis			14. MOTHER'S MAIDEN NAME Ida Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of the cervix (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years					
19. 171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 3 19 68 to Nov. 4 19 68 , that (I) (we) last saw the deceased alive on Nov. 4 19 68 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry S. Crist, MD</i> DEGREE				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) Henry S. Crist, Surgeon (R) DEGREE			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-11-68	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968	25B. NAME OF REGISTRAR 11-11-68	25C. FUNERAL DIRECTOR Sullivan, H. H. - 911 Arlington Ave		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

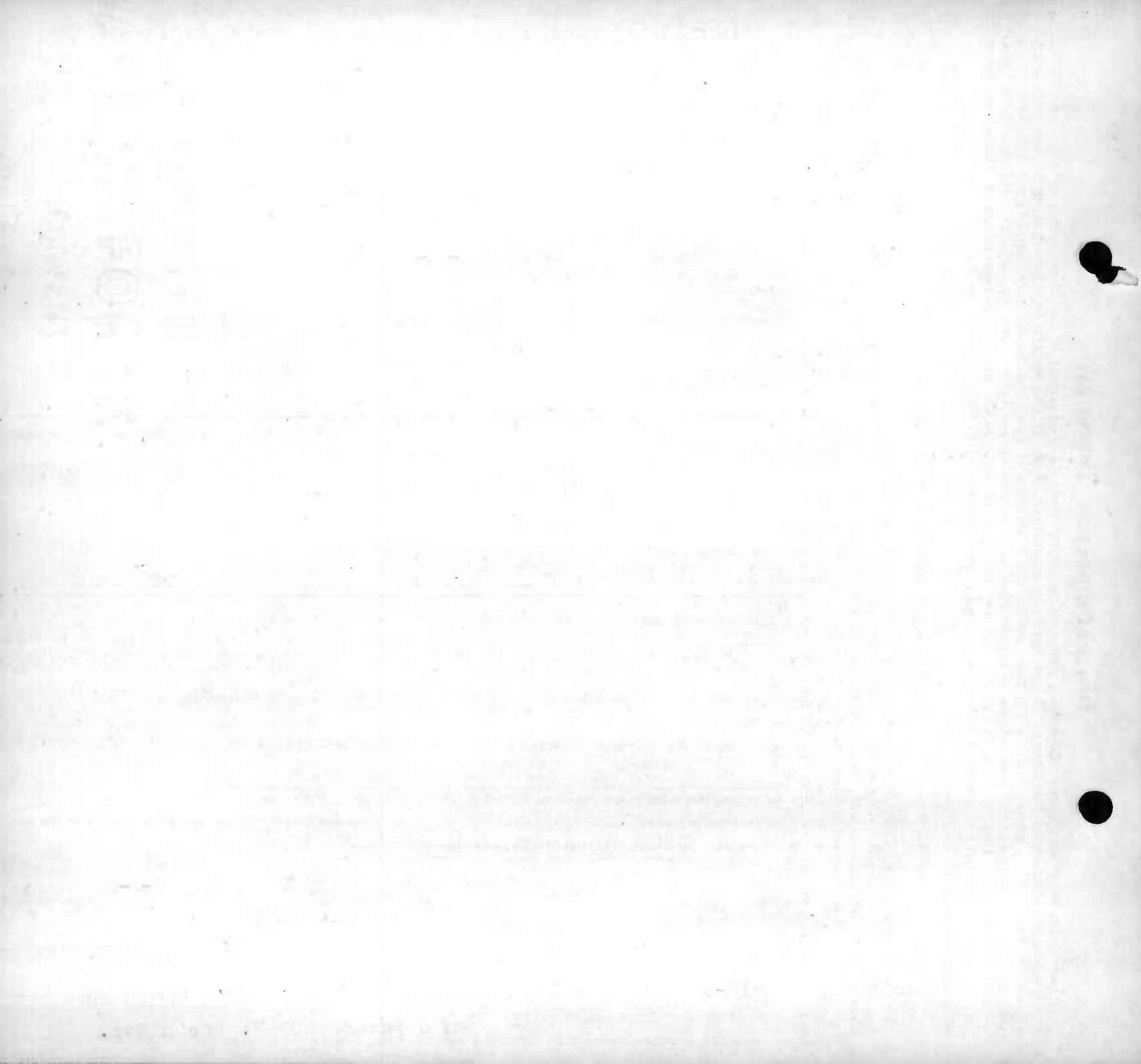
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11270
BIRTH NO. 68-11270				M.
1. NAME OF DECEASED (Type or Print) Katherine Weihrauch		2. DATE AND HOUR OF DEATH 11-5-1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 53-00 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 306 Dale Avenue 21206		
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-1871	9. AGE (In years lost birthday) 96 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Williamport Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerome King		
14. MOTHER'S MAIDEN NAME R. Shook		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-03-4495		17. INFORMANT ADDRESS Mrs Genevieve W. Bell 306 Dale Avenue 6		
18. 44091-174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Circulatory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic vascular dis. DUE TO, OR AS A CONSEQUENCE OF: (C) Cancer of the left breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 25 yrs. 20 yrs.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 450.0 II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1953 to 11/6/68 and that (I) (we) lost saw the deceased alive on 11/6/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Richard R. Rigler		23B. DATE SIGNED 11/8/68		23C. PHYSICIAN'S NAME (Type) RICHARD R. RIGLER, M.D.
23D. ADDRESS 1 W. Overlea Ave., Balto, Md. 21206				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-8-1968	24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, City Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968	25B. NAME OF REGISTRAR Lassahn	25C. FUNERAL DIRECTOR Lassahn	25D. ADDRESS 7401 Belair Road	

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. E-120		68-11271		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11271	
1. NAME OF DECEASED (Type or Print) ADA M. EPPS				2. DATE AND HOUR OF DEATH November 8, 1968 11 ⁰⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 4940 EASTERN AVE. 21224 BALTIMORE CITY HOSPITALS				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 21224 4940 Eastern Avenue, Baltimore City Hospitals			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-12	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GEORGIA		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Frank Wright				
14. MOTHER'S MAIDEN NAME Hattie			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. 214-24-3617			17. INFORMANT ADDRESS BCH RECORDS: 4940 EASTERN AVE. 21224				
18. 2509 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) HYPERTENSIVE CARDIO-VASC. DISEASE CHRONIC RENAL DISEASE			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/24/68 to 11/8/68, that (I) (we) lost saw the deceased alive on November 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Torres				23B. DATE SIGNED 11-8-68		23C. PHYSICIAN'S NAME (Type) JOSE TORRES	
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. 21224				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-13-68				24C. NAME OF CEMETERY or CREMATORY Balto National Cemetery Balto., Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

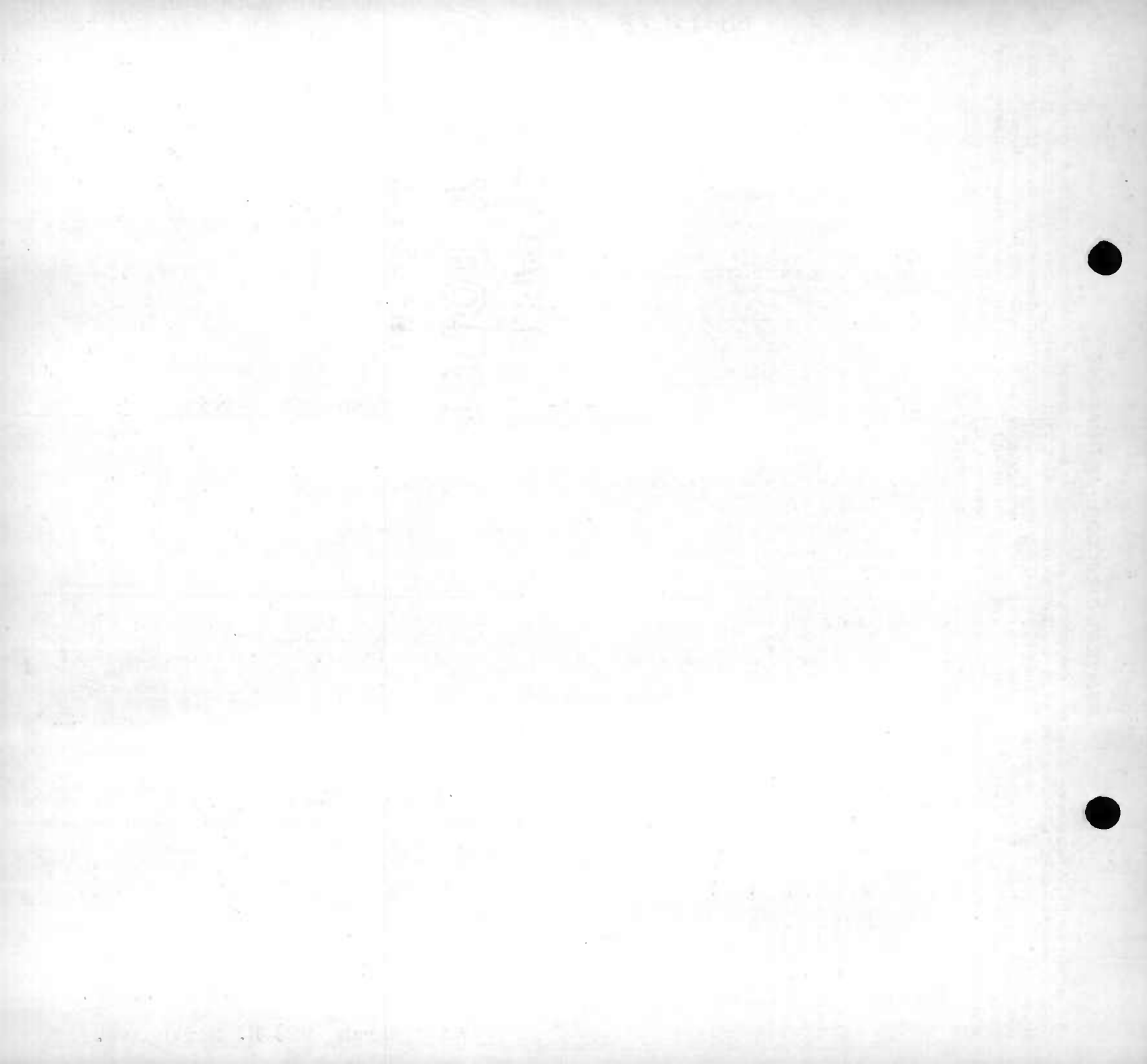
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BALTIMORE CITY HEALTH DEPARTMENT
68-11272 CERTIFICATE OF DEATH

REG. NO.

68-11272

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE BROWN		2. DATE AND HOUR OF DEATH 11/9/68 7:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 12-03	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEM. HOSP.				C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 2525 BARCLAY ST.	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/22/94	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) TENNESSEE	
13. FATHER'S NAME ?				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No?				16. SOCIAL SECURITY NO. 224-05-8770	
17. INFORMANT Annie Brown				ADDRESS 2525 Barclay Street	
18. 402 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) ATHEROSCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. 5 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II Y.S					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/7 19 68 to 11/9 19 68 , that (I) (we) last saw the deceased alive on 11/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan O. Jensen, MD				23B. DATE SIGNED 11/9/68	
23C. PHYSICIAN'S NAME (Type) ALAN O. JENSEN MD				23D. ADDRESS UNION MEM. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.			



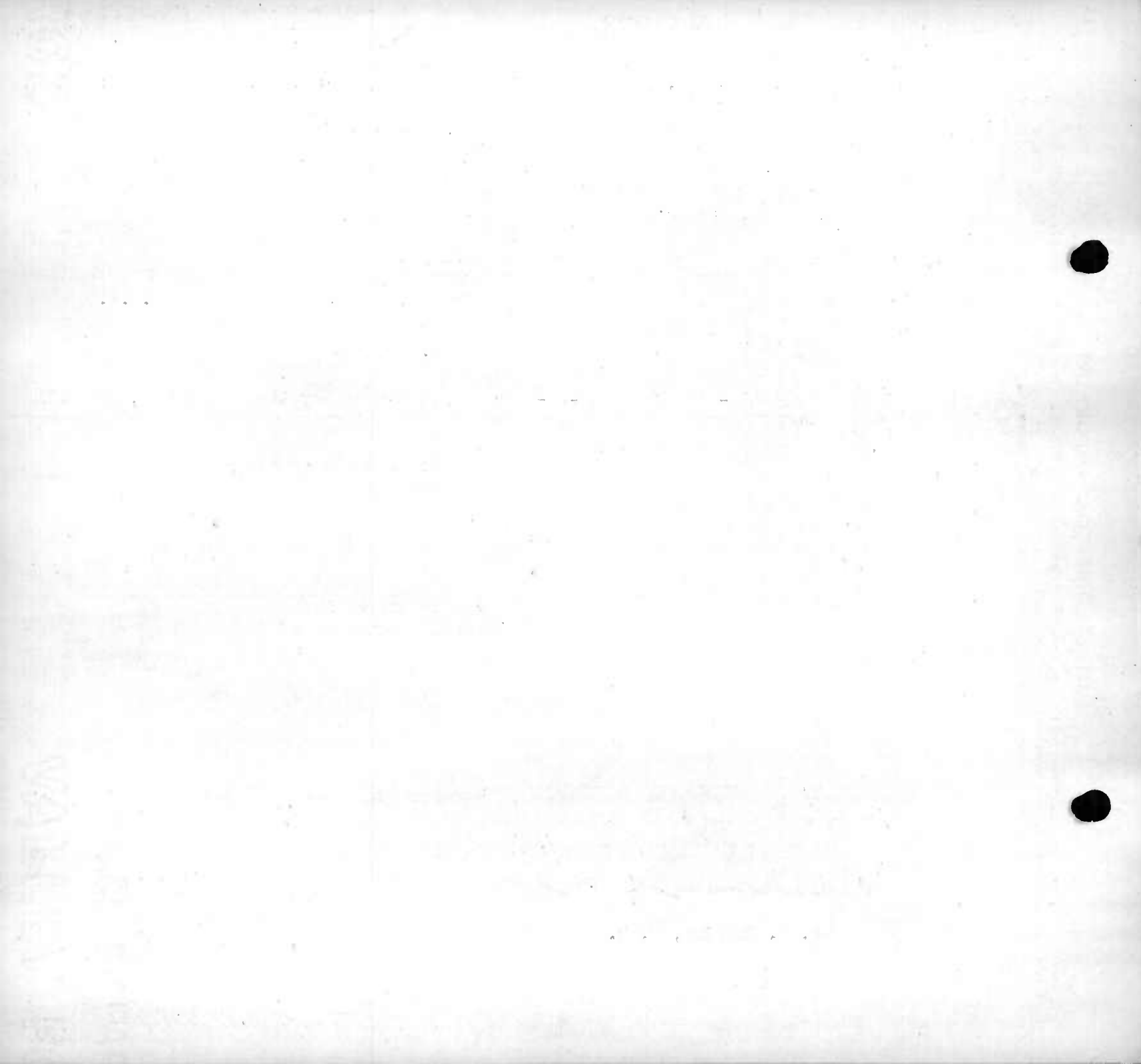
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
68-11273 CERTIFICATE OF DEATH

REG. NO. 68-11273

BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS, Thomas C.		2. DATE AND HOUR OF DEATH November 8, 1968 7:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Towson		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY PRIVATE HOMES		8. DATE OF BIRTH 12/15/22	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Ellas Frazier		9. AGE (In years last birthday) 45	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3/13/43 - 12/8/45		16. SOCIAL SECURITY NO. 212-20-4959		11. BIRTHPLACE (State or foreign country) Towson, Maryland	
17. INFORMANT Records VA Hospital Baltimore, Md 21218		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 571.0 I (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute brain syndrome		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Laennics cirrhosis Chronic pancreatitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 14th 19 68 to November 8th 19 68 , that (I) (we) last saw the deceased alive on November 8th 19 68 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. H. Twining M.D.				23B. DATE SIGNED 11/8/68	
23C. PHYSICIAN'S NAME (Type) R. H. Twining, M. D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/12/68		24C. NAME OF CEMETERY or CREMATORY Balto. National	
24D. LOCATION (City, town, or county) Balto. Md.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Wm. L. Chatham Jr.		25C. FUNERAL DIRECTOR 1701 M^{rs} Callahan St. Balt.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11274 **CERTIFICATE OF DEATH** REG. NO. 68-11274

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES RALEY		2. DATE AND HOUR OF DEATH 11/8/68 11:33 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEM. HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1417 McCULLOCH ST.		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/03/19	9. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Angelus, U.S.A.	
13. FATHER'S NAME UNKNOWN (William Thomas Raley)			14. MOTHER'S MAIDEN NAME UNKNOWN (Mattie Raley)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Rosie Raley 2739 Edmondson	
18. 202.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Rhyphorua CARDIAC FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL PNEUMONIA with abscess. Pulmonary emboli. Y.S.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/6 1968 to 11/8 1968 , that (I) (we) last saw the deceased alive on 11/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE Allan D. Jensen M.D.				23B. DATE SIGNED 11/8/68	
23C. PHYSICIAN'S NAME (Type) ALLAN D. JENSEN, M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL UNION MEM. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/12/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett Funeral Home Baltimore, Md.			

EO

X

2-2-1948

(Conf. Sec.)

(William H. Hall)

1. The first step is to
determine the scope of the project.

17.0

John W. Hall

2.1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-11275	
1. NAME OF DECEASED (Type or Print) MR ROBERT DAVIS		2. DATE AND HOUR OF DEATH Nov 8/68 1208A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp.		A. STATE Md		B. COUNTY 53-00	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1008 I Street			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-02	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Steel Worker		11. BIRTHPLACE (State or foreign country) Richmond, Virginia	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME Laura Davis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-07-9155		17. INFORMANT Mrs. Alva Davis	
18. 410.914-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Asphyxia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction 2° to ASD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1208 Nov-8 19 68 to 1208 Nov-8 19 68 , that (I) (we) last saw the deceased alive on 1208 Nov-8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A/S G. Lushakov		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov-8, 1968	
23C. PHYSICIAN'S NAME (Type) A/S G-LUSHAKOV		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-11-68	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.	
				ADDRESS 1701 Laurens St	

Final version: 1008 I sheet
4-14-62

Richard
Lester
Davis
1008-1122 Mr. Alvin Davis
No.

11-1-62
1008-1122 Mr. Alvin Davis
1008-1122 Mr. Alvin Davis

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11276

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

(Melton) MILTON L. OWENS

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

November 8, 1968

6:35 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

MERCY HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

November 8, 1968

6:35 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-6-1944

10. AGE (In years last birthday)

24

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1914 N. Aisquith Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph M. Owens

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Delvale Ice Cream

15. MOTHER'S MAIDEN NAME

Leola Owens

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

214-40-3309

18. INFORMANT

Mrs. Leola Owens

ADDRESS

1917 N. Aisquith

19.

304.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Intravenous narcotism

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

323X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 9, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/12/68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 11 1968

25B. NAME OF REGISTRAR

Robert E. Jankovic

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOME

1701 Laurens St., Balto., Md.

ADDRESS

80-2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11277

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE M. COX

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☐ November 10, 1968 7:08 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

LUTHERAN HOSPITAL (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year Hour
November 10, 1968 7:08 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

7-30-1915

10. AGE (In years
lost birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3402 W. North Avenue

11. BIRTHPLACE (State or foreign country)

Anderson Co., N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Cox

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffer

14B. KIND OF BUSINESS OR INDUSTRY

Henryton Hosp.

15. MOTHER'S MAIDEN NAME

Lottie Cox

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

250-34-0505

18. INFORMANT

Mrs. Hattie Cox 3402 W. North Avenue

ADDRESS

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

412.4

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

422.1 II

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 10, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-15-68

24C. NAME of CEMETERY or CREMATORY

Timmonsville Ch. Cem.

24D. LOCATION (City, town, or county) (State)

Wadesboro,

N.C.

25A. DATE REC'D BY HEALTH DEPT.

NOV 11 1968

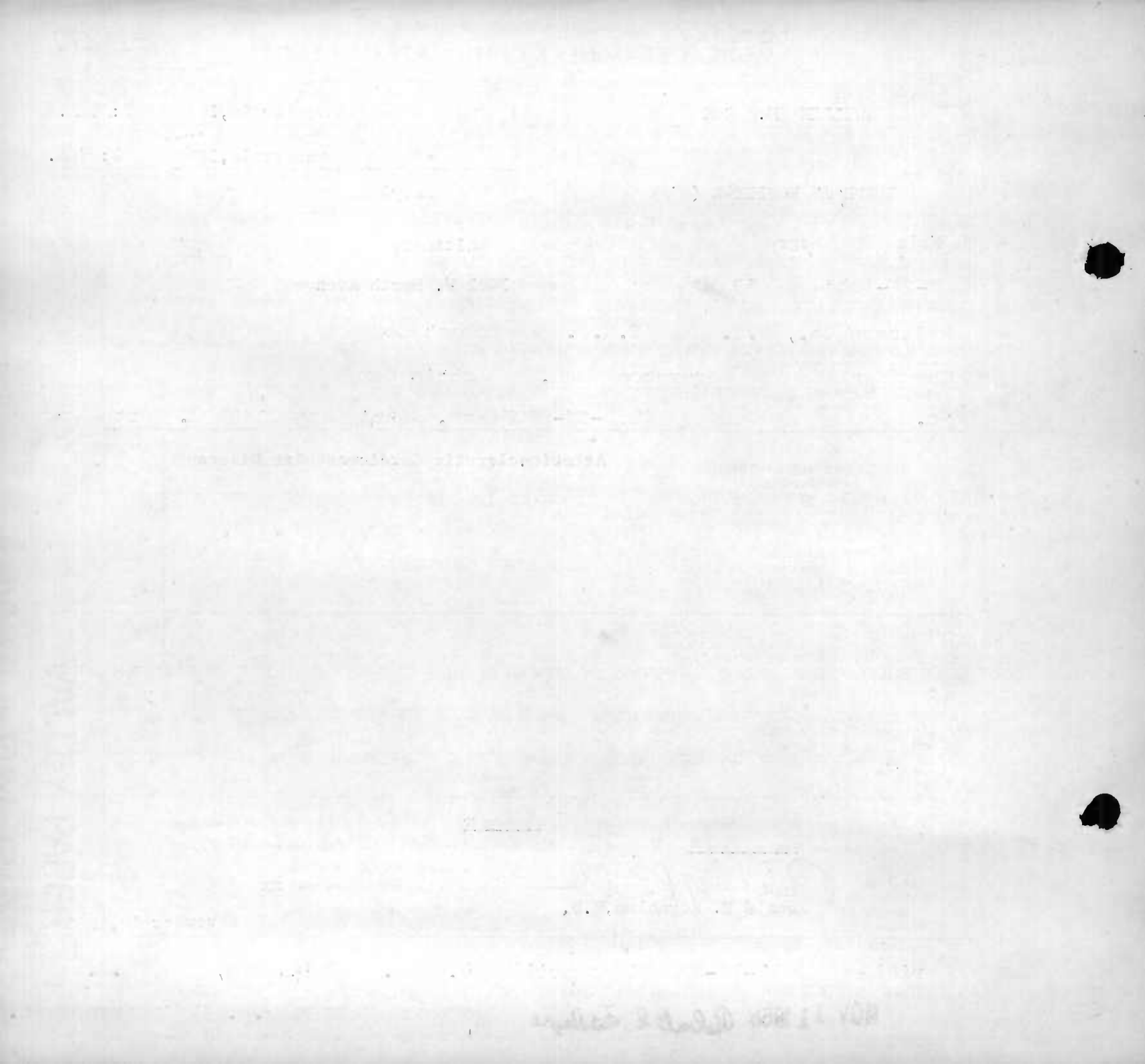
25B. NAME OF REGISTRAR

Robert E. Fendley

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS

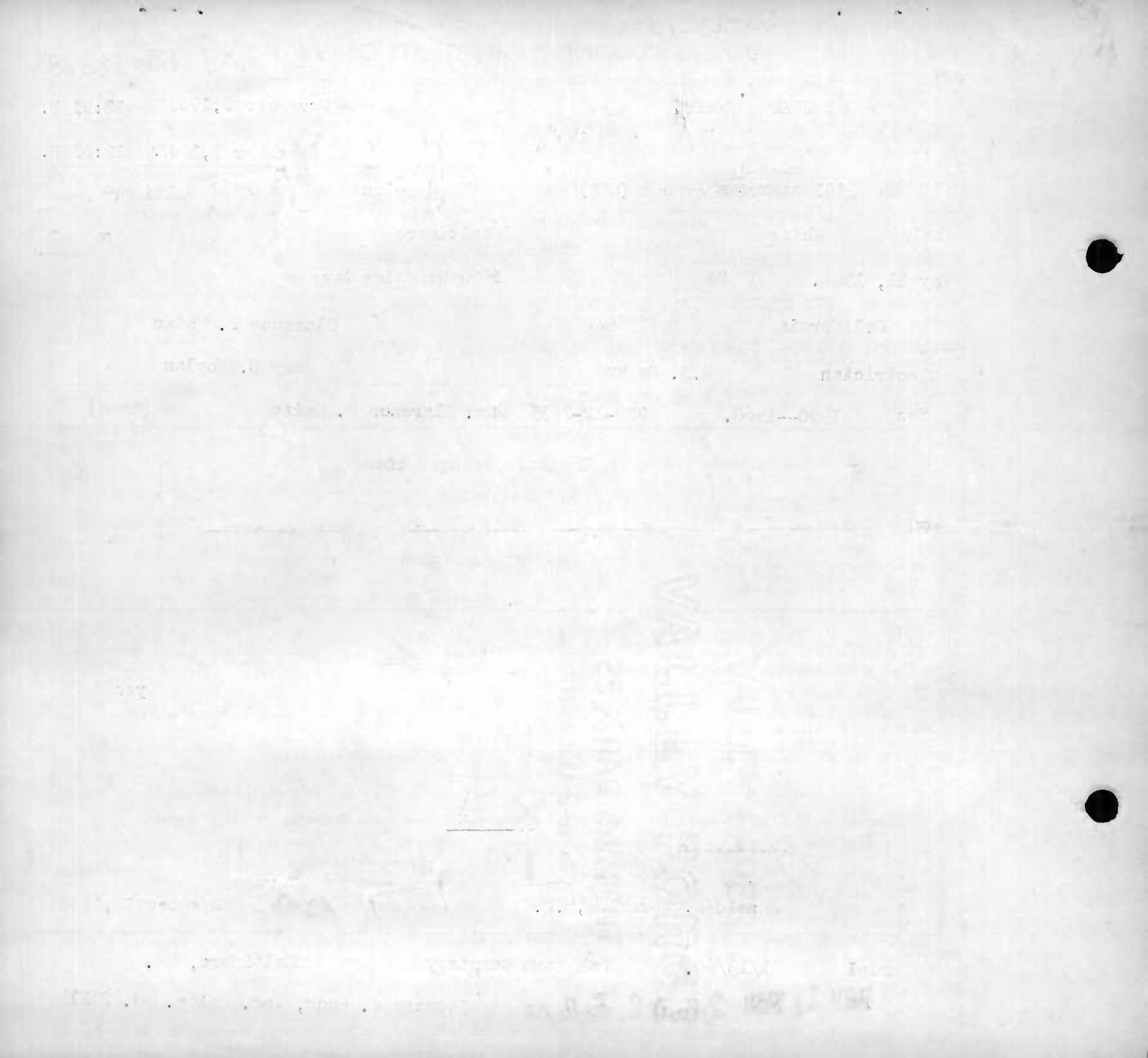


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11278

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PHILIP W. WAITZ		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 9, 1968 12:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Woodring 3163 Woodring Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 9, 1968 12:35 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH May 11, 1944.		10. AGE (In years last birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		14B. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
15. MOTHER'S MAIDEN NAME Mary B. Moylan		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1960--1968.	
17. SOCIAL SECURITY NO. 220-42-7935		18. INFORMANT ADDRESS Mr. Clarence B. Waitz (Same)	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 10, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68.	
24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR Ronald E. Feltz	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11279 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11279

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lena Schmidt-Heill		November 9, 1968 4:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
House In The Pines Nursing Home 5837 Belair Road				Md. Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				6001 Glenoak Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5/26/1882	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry Mai			Rose ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214222114D		Mrs. Elizabeth Zizwarek - Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				1 day	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES				10 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.					
260X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/28/68 19 to 11/9 1968, that (I) (we) last saw the deceased alive on 11/7/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Conrad L. Richter				11/9/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Conrad L. Richter		3128 Harford Rd., Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/11/68		Moreland Cemetery	
				Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 11 1968		Leonard J. Ruck, Inc		Baltimore, Md.	

Handwritten signature

Antonieta de la Cruz
Duchess of Wellington

Mr

11/11/18

General Pitt

11/11

11/11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Medical Examiner
 Mr. Macon

Do Be Approved By
 FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA W. HANLEY		2. DATE AND HOUR OF DEATH 11-11-68 12:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		M. 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5910 FARMVIEW Ave. 21206		5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-22-91		9. AGE (In years last birthday) 77		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN DRONEY		14. MOTHER'S MAIDEN NAME Anna MC DERMOTT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No	
16. SOCIAL SECURITY NO. 215-05-4219		17. INFORMANT Mr. Raymond C. Hanley		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOPHLEBITIS, LOWER EXTREMITY	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fracture of L Femur		21. DATE OF OPERATION 10-24-68		22. DATE OF OPERATION 10-24-68	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of L Femur		24. AUTOPSY? (Yes or No) No		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NURSING HOME		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00	
29. TIME OF INJURY (Month) (Day) (Year) NOV. 11, 1968		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		31. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 23 1968 to NOV. 11, 1968 and that (I) (we) last saw the deceased alive on NOV 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Salville		23B. DATE SIGNED 11-10-68		23C. PHYSICIAN'S NAME (Type) RICARDO SALVILLA	
23D. ADDRESS UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68	
24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Long Green, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968	
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS	

UNION MEMORIAL HOSPITAL

ENTRANCE 2117

810 TENNESSEE

4-21-11

X

RECEIVED

ENRY MC BEEMER

MEETING ROOM

FORWARDED

RECEIVED

RECEIVED

10-24-11

RECEIVED

11-11-11

NOV 11 1911

OCT 23 11 11

NOV 11 1911

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UNION MEMORIAL HOSPITAL

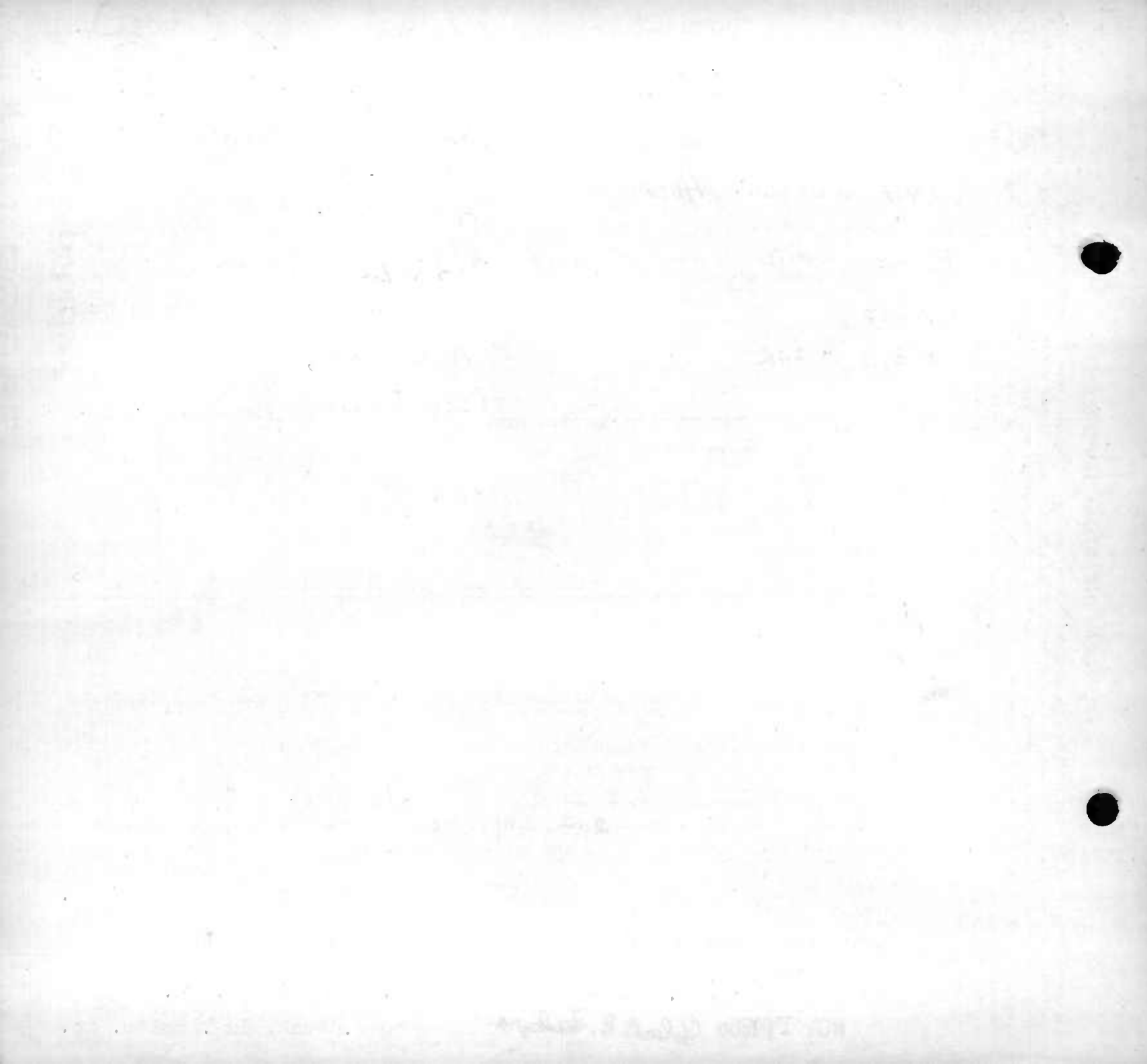
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11-10-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11281
BIRTH NO. 68-11281		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) TOMKOV, Elisabeth		2. DATE AND HOUR OF DEATH NOVEMBER 7, 1968 3:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT. 10 Box 83 G		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/96	9. AGE (In years last birthday) 72 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ESTONIA
13. FATHER'S NAME HANS KAAR		14. MOTHER'S MAIDEN NAME NORTMAN, Liisa		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-46-4783		17. INFORMANT DLEG TOMKOV ADDRESS RT. 10, Box 83 G PASADENA MD, 21122
18. 15411 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Intestinal obstruction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Peritonitis (B) DUE TO, OR AS A CONSEQUENCE OF: St. p. carcinoma rectum (C) years		
19. 154X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED colostomy		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/29 1968 to 11/7 1968 , that (I) (we) last saw the deceased alive on 2 p.m. 11/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature] MD.		23B. DATE SIGNED 11/8/68.		23C. PHYSICIAN'S NAME (Type) FREIDON MALEK MD.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.
25A. DATE REC'D BY HEALTH DEPT. NOV 11 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. ADDRESS Bon Secours Hospital		



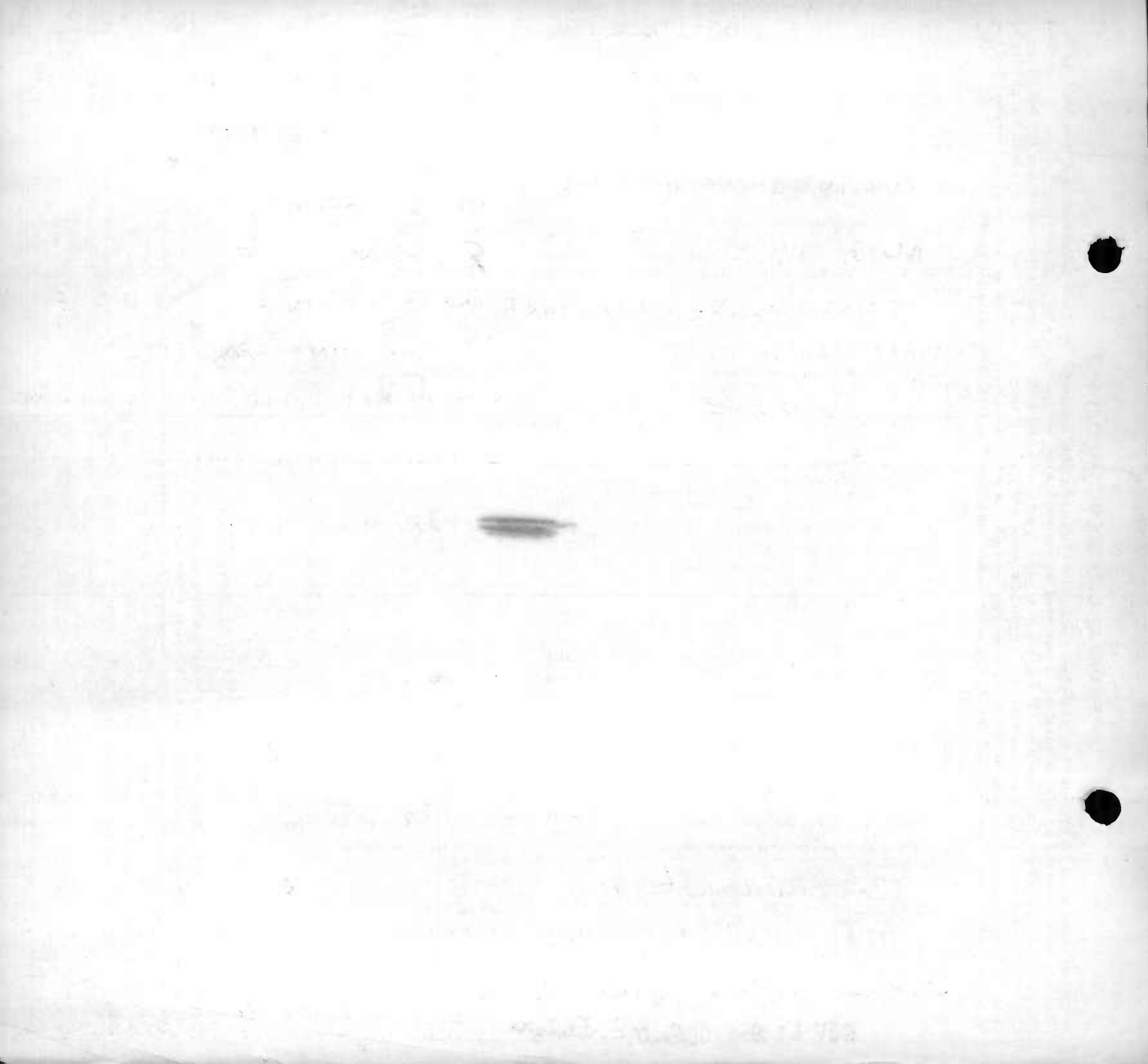
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11282 CERTIFICATE OF DEATH

REG. NO. 68-11282

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JESSE J. AULT		2. DATE AND HOUR OF DEATH 11-9-68 3:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1115 S. CAREY ST. 23		
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-93	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER Bldg. Const.		10B. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC SALEN AULT			14. MOTHER'S MAIDEN NAME CHRISTINA CAMPBELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 379-04-3236		17. INFORMANT ADDRESS UTAI RUANGWIT, M.D., 100 N. CALHOUN ST.	
18. 197.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIOPULMONARY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF THE LIVER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10-2-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POSSIBLE CARCINOMATOSIS		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-25-1968 to 11-9-1968 . that (I) (we) last saw the deceased alive on 11-9-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Utai Ruangwit, M.D.				23B. DATE SIGNED 11-9-68	
23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT, M.D.		23D. ADDRESS FRANKLIN SQUARE HOSPITAL, BALTO, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-12-68		24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN	
24D. LOCATION GLEN BURNIE, MD.		24E. DATE REC'D BY HEALTH DEPT. NOV 11 1968			
25A. NAME OF REGISTRAR Robert E. Johnson		25B. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab Funeral Home, 2101 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11283 CERTIFICATE OF DEATH

REG. NO. 68-11283

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MYRA HARBAUGH		2. DATE AND HOUR OF DEATH NOVEMBER 9 1968 2:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION THE LINCOLN MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 314 SUFFOLK RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-22-93	9. AGE (In years lost birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - TEACHER - EDUCATION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA U.S.A.		13. FATHER'S NAME FRANK R. HARBAUGH		14. MOTHER'S MAIDEN NAME FANNIE WOODWARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-1234-1		17. INFORMANT (MART) MRS. JOHN BANDEL	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL HEMORRHAGE (B) CHRONIC ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (C) 5 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 5 1968 to NOVEMBER 9 1968 , that (I) (we) last saw the deceased alive on NOVEMBER 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chun Kee Ryu M.D.		23B. DATE SIGNED NOVEMBER 9, 68			
23C. PHYSICIAN'S NAME (Type) CHUN KEE RYU M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/12/68		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 11 1968		24F. NAME OF REGISTRAR Chun K. Ryu	
24G. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		24H. ADDRESS 4905 York Rd. Baltimore, Md. 21212			

THE UNION MEMORIAL HOSPITAL
FEMALE WHITE
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02-23-93 48
JIM SUFFOLK RD

LEWIS & HARRISON
FEMALE WHITE
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THE UNION MEMORIAL HOSPITAL
FEMALE WHITE
X
02-23-93 48
JIM SUFFOLK RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11284 CERTIFICATE OF DEATH

REG. NO. 68-11284

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BANKS, George WASHINGTON</u>		2. DATE AND HOUR OF DEATH <u>Nov - 11 - 1968</u> <u>630 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Lincoln Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>27 N. Carey St</u>		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>820 Chauncey Ave.</u>					
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1883</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN GEO. W. BANKS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Susie Harris</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-44-0657</u>		17. INFORMANT <u>BESSIE BANKS 820 CHAUNCEY AVE</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CORONARY Thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-5-1968</u> to <u>11-11-1968</u> , that (I) (we) last saw the deceased alive on <u>11-11-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harris Seunarine, M.D.</u>		23B. DATE SIGNED <u>11-11-68</u>			
23C. PHYSICIAN'S NAME (Type) <u>Harris Seunarine</u>		23D. ADDRESS <u>1801 GREENBERRY RD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>11/15/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 12 1968</u>		25B. NAME OF REGISTRAR <u>James E. Taylor</u>		25C. FUNERAL DIRECTOR <u>James E. Taylor</u>	
				ADDRESS <u>635 N. G. Union St</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11285				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11285	
1. NAME OF DECEASED (Type or Print) ARCHIE JONES				2. DATE AND HOUR OF DEATH NOVEMBER 6, 1968 2:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 2014 EDMONDSON AVE B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 16			
5. SEX M	6. RACE N N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/09	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10B. KIND OF BUSINESS OR INDUSTRY Gen. Contractor		11. BIRTHPLACE (State or foreign country) Howard Co. MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME CARRIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-145535A		17. INFORMANT Isabelle Campbell 2014 Edmondson Ave			
18. 157.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TERMINAL CA PANCREAS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Old Myocardial Infarction, OBSTRUCTIVE PNEUMONIA							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1964 to Nov. 6, 1968 , that (I) (we) lost saw the deceased alive on Nov. 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carlos M. Ramirez, MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Nov. 6, 1968	
23C. PHYSICIAN'S NAME (Type) CARLOS M. RAMIREZ, MD				23D. ADDRESS 611A CRANBROOK RD. COCKEYSVILLE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/9/68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE RECEIVED NOV 12 1968				25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR Marshall P. Hayes 6387 Gehman	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11286

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68-11286

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Albert J Nocar		2. DATE AND HOUR OF DEATH 11/9/68 11:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 25-05		
5. SEX m		6. RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship fitter, rtd		10B. KIND OF BUSINESS OR INDUSTRY USCG rtd.		8. DATE OF BIRTH 8/17/09	
13. FATHER'S NAME John Nocar		14. MOTHER'S MAIDEN NAME Marie Vanick		9. AGE (In years last birthday) 59	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Hospital Chart	
18. 204.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic Shock			
		(B) Pulmonary Infarction due to Embolism DUE TO, OR AS A CONSEQUENCE OF:		days	
		(C) Chronic Lymphocytic Leukemia		3 1/2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 204.0 II		None			
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from 10/10/68 19 to 11/9/68 19 that we (we) last saw the deceased alive on 11/9/68 19 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE Henry S. Crist		23B. DATE SIGNED 11/9/68		23C. PHYSICIAN'S NAME (Type) Henry S. Crist MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-13-68		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Balto. 21225, Md		25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR John H. Hahn	
25C. FUNERAL DIRECTOR John H. Hahn		25D. ADDRESS 4200 Pennington Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11287 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11287

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARSON, GEORGE, Sr.		2. DATE AND HOUR OF DEATH NOV. 9, 1968 9:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 20-05		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSP. NORTH CHARLES ST. BALTIMORE MARYLAND			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY STEEL		8. DATE OF BIRTH 6/6/1895	
13. FATHER'S NAME GEORGE CARSON		14. MOTHER'S MAIDEN NAME XXXXXXXXXX Lillian Bell		9. AGE (In years lost birthday) 73	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 215-01-5838		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT XXXXXXXXXXXXXXXXXXXX Mrs. Mary M. Haney		ADDRESS 2110 Eagle Street 21223		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 4 MONTHS			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 20, 19 68 to Nov. 9, 19 68 , that (I) (we) last saw the deceased alive on Nov. 9, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Gracias Y. Faustino, M.D. OEGREE				23B. DATE SIGNED Nov. 9, 1968	
23C. PHYSICIAN'S NAME (Type) DR. GRACIAS Y. FAUSTINO, M.D. OEGREE				23D. ADDRESS NORTH CHARLES GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-13-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 12 1968	
25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

DATE 10/10/73
 X
 MARYLAND
 STEEL
 GEORGE CARRON
 NO
 BRANCHES CARBON
 BRANCHES CARBON

DEBORAH V. BOUTWELL
 X
 MARYLAND
 STEEL
 GEORGE CARRON
 NO
 BRANCHES CARBON
 BRANCHES CARBON

1
m-265

68-11288 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGIA A. MC CORMICK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> onight between 11/12/1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 813 W. Lombard Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 1968 2:30 PM	
6. SEX F		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2504	
9. DATE OF BIRTH May 12, 1912		10. AGE (In years last birthday) 56 260x	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
13. FATHER'S NAME Edward Buckland		15. MOTHER'S MAIDEN NAME Ella Hodge	
18. INFORMANT Mrs. Jean Hudson		ADDRESS 4103 8Th. Street Brooklyn, Md.	
19. E 966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple stab wounds.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 813 W. Lombard Street		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 18-03	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED NOV 3. 68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68	
24C. NAME of CEMETERY or CREMATORY Sunset Mem. Park		24D. LOCATION (City, town, or county) (State) Beckley, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Howard H. Hubbard Funeral Home		ADDRESS 4107 Wilkens Ave. Baltimore, Md 21229	

Handwritten scribble or signature in the left margin.

Nov 3 1960

Handwritten signature or initials.

WALLEY PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11289 CERTIFICATE OF DEATH

REG. NO.

68-11289

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Fredrick H. Rapp, Jr.		2. DATE AND HOUR OF DEATH 11/07/68 7:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Md. B. COUNTY 26-10		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital Baltimore, Maryland 21205			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation Dept.		10B. KIND OF BUSINESS OR INDUSTRY Balt. City		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Fredrick H. Rapp, Sr			14. MOTHER'S MAIDEN NAME Mary Weber		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Martha Rapp	
18. 3-40.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ventricular Fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory Arrest		(B) DUE TO, OR AS A CONSEQUENCE OF: 3min			
(C) DUE TO, OR AS A CONSEQUENCE OF: Block of Tracheostomy tube					
19. DATE OF OPERATION 10/27/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated Appendix		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1 1968 to 11/7 1968 , that (I) (was) last saw the deceased alive on 11/7 1968 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (view) view the body after death.					
23A. SIGNATURE Richard G. Katz				23B. DATE SIGNED 11/7/68	
23C. PHYSICIAN'S NAME (Type) Richard G. Katz				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-12-68		24C. NAME of CEMETERY or CREMATORY Prospect Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Towson Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968			
25B. NAME OF REGISTRAR Robert E. Sadyrna		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St.			

x

Richard O. K. 1948

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11290
68-11290				CERTIFICATE OF DEATH
BIRTH NO. 68-21416		1. NAME OF DECEASED (Type or Print) BABY GIRL ODOM		
2. DATE AND HOUR OF DEATH 11/6/68 9:15P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD. B. COUNTY ANNE ARUNDEL		
UNIV. OF MD. HOSPITAL		C. CITY OR TOWN Glen Burnie		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 107 5TH GLEN BURNIE				
5. SEX Female	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/68	9. AGE (In years last birthday) 60
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
chevrolet		USA MD.		U.S.A.
13. FATHER'S NAME Edgar - Odom		14. MOTHER'S MAIDEN NAME Judy Eller Odom		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 415-689516		17. INFORMANT Father
				ADDRESS Glen Burnie 107 5th Ave.
18. 758.9 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Respiratory Arrest		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) Multiple Congenital Anomalies		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		(C) _____		
19. 759.3 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11/6/68 to 11/6/68 , that (I) (we) lost saw the deceased alive on 11/6/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 11/6/68		
23C. PHYSICIAN'S NAME (Type) [Signature]		23D. ADDRESS Glen Burnie, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 Nov. 68	24C. NAME OF CEMETERY OR CREMATORY Hughes Cemetery	24D. LOCATION (City, town, or county) (State) Roane Mountain, Tennessee
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]

FUNERAL DIRECTOR: IMPORTANT

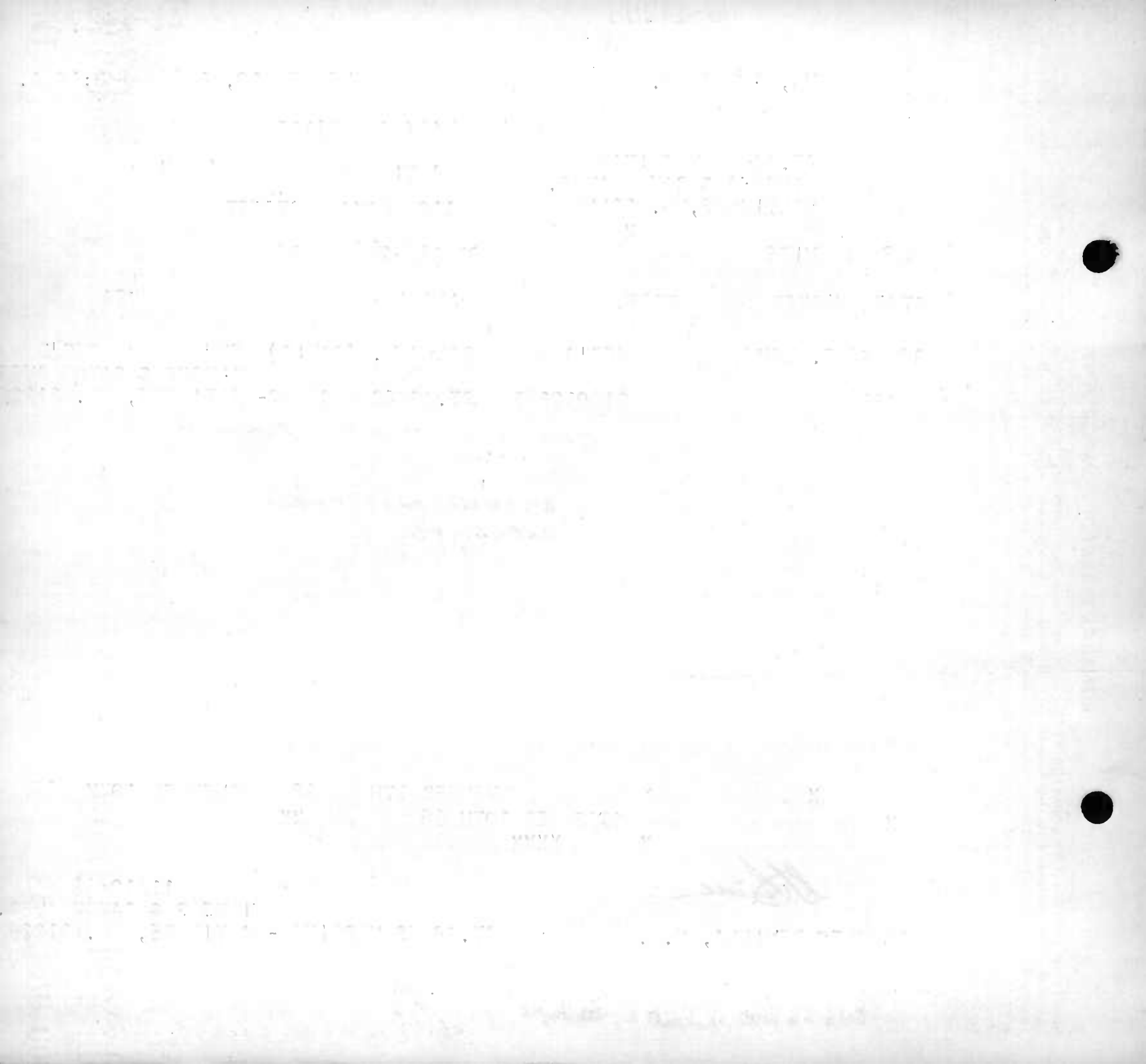
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11291	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SABOY Joseph JOHN		2. DATE AND HOUR OF DEATH 11/7/68 5:30 pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Harford	
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Joppa D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker Retired		10B. KIND OF BUSINESS OR INDUSTRY Railroad		8. DATE OF BIRTH 3/19/24	
13. FATHER'S NAME Saboy, John Joseph		14. MOTHER'S MAIDEN NAME ? Unknown		9. AGE (In years last birthday) 74	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-03-6049		12. CITIZEN OF WHAT COUNTRY? U.S. citizen	
17. INFORMANT Edward J. Saboy, 2707 Gibbons Ave., Baltimore		ADDRESS Md.			
18. 412.21-173.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Congestive heart failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular disease		6 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Epithelioma on neck					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1/68 to 11/7/68 , that (I) (we) last saw the deceased alive on 11/7/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Yoon Rhim, M.D.				23B. DATE SIGNED 4/7/68	
23C. PHYSICIAN'S NAME (Type) SANG YOUN RHIM				23D. ADDRESS South Baltimore General Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 11, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore				24E. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11292	
68-11292				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LEHN, ANDREW E.		2. DATE AND HOUR OF DEATH NOVEMBER 10, 1968 8:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21223 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY STEEL		8. DATE OF BIRTH 02/24/92 9. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE E. LEHN	
14. MOTHER'S MAIDEN NAME SALLY V. (DAVIS) LEHN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 216012387	
17. INFORMANT WILKENS & CATON AVES ST. AGNES RECORDS-BALTIMORE, MD. 21229		18. CAUSE OF DEATH CHRONIC OBSTRUCTIVE PULMONARY DISEASE. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASTHMA AND CHRONIC BRONCHITIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 7TH 1968 to NOVEMBER 10TH 1968 , that (X) (we) last saw the deceased alive on NOVEMBER 10TH 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodolfo Revilla</i>		23B. DATE SIGNED 11/10/68		23C. PHYSICIAN'S NAME (Type) RODOLFO REVILLA, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME OF CEMETERY or CREMATORY London Park Crem.	
24D. LOCATION (City, town, or county) (State) Balt. Md.		25A. DATE RECD BY HEALTH DEPT. NOV 12 1968			
25B. NAME OF REGISTRAR Robert E. Williams		25C. FUNERAL DIRECTOR John J. Cowan - Sr., Inc. 901 Hollins St. Balt. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11293	
68-11293				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HAIR, NAOMI G.		2. DATE AND HOUR OF DEATH 11¹⁵ Nov. 1968 0845hrs. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY ST. MARY'S		
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital Baltimore - MD 21231			C. CITY OR TOWN SEVERN - MD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER Box 618 TELEGRAPH RD			F. STREET AND NUMBER Box 618 TELEGRAPH RD		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-25		9. AGE (In years last birthday) 43
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Mach-oper Kirby Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME FLOYD JACOBS		
14. MOTHER'S MAIDEN NAME DOROTHY WATSON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		
16. SOCIAL SECURITY NO. 219-12-6467			17. INFORMANT Mr Joseph L. Hair		
18. ADDRESS Same			19. ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Small bowel obstruction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Peritoneal Adhesions		
ANTECEDENT CAUSES			(B) PREVIOUS OPERATIONS Previous operations		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) RADIATION TREATMENT FOR CARCINOMA OF COLON Radiation Treatment for Carcinoma of Colon		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 171X II					
19A. DATE OF OPERATION Nov 5 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Does not apply	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Does not apply		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR? Does not apply	
22. I certify that (1) (this hospital) attended the deceased from Nov 5 1968 to Nov 11th 1968 , that (2) (we) last saw the deceased alive on Nov 11th 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. F. Azam M.B.B.S.				23B. DATE SIGNED Nov 11th 1968	
23C. PHYSICIAN'S NAME (Type) A. F. AZAM M.B.B.S.				23D. ADDRESS Balto. Md. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY Glen Haven	
24D. LOCATION (City, town, or county) (State) Glen Burnie Md. 21061		25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR McCallig FH 237 Potomac Ave 21225			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11294				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11294	
1. NAME OF DECEASED (Type or Print) GLADYS STERNER				2. DATE AND HOUR OF DEATH NOVEMBER 9TH 1968 12.45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (If deceased lived in institution, residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) PARKTON D. STREET ADDRESS (If rural, give location) FALLS ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-17-18	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgetown, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE RILEY			14. MOTHER'S MAIDEN NAME SARAH SMIDDY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 405 14 9985		17. INFORMANT ADDRESS Hospital Records		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Metastatic CA of lung				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3-6 mos.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 162.1							
19A. DATE OF OPERATION 11/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA @ lung		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 10/28 19 68 to 11/9 19 68 , and that (1) (we) lost saw the deceased alive on 11/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Denis H. Turas				23B. DATE SIGNED 11/9/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Denis H. Turas		JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE Nov. 12, 68	24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Cockeysville, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md.			

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James H. Davis
James H. Davis

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11295 CERTIFICATE OF DEATH

REG. NO. 68-11295

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BRUEHL, Katie A		11-9-68 4:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Ctr.				Rt. 9, Box 129 - Pasadena, Md. 5200	
				C. CITY OR TOWN D. INSIDE CITY LIMITS? Pasadena YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		8. DATE OF BIRTH 5-17-69	
13. FATHER'S NAME Charles Martin		16. SOCIAL SECURITY NO. 214-54-1963		9. AGE (In years last birthday) 99	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT Goe. W. Crowley, 7425 Brookwood Ave. 21236		11. BIRTHPLACE (State or foreign country) Maryland	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (B) chronic bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (C)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/2 1968 to 11/9 1968, that (I) (we) last saw the deceased alive on 11/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen H. Macht MD				23B. DATE SIGNED 11/9/68	
23C. PHYSICIAN'S NAME (Type) ALLEN H. MACHT MD				23D. ADDRESS 2 E. Repl St Balto, Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-12-1968		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Methodist	
24D. LOCATION Balto. Co., Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204		25D. ADDRESS		25E. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11296

BIRTH NO.

1. NAME OF DECEASED ANGELA R. KAMINSKI

(Type or Print)

Mrs Angela Kaminski

2. DATE AND HOUR OF DEATH

11/9/68 10-15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home & Hosp.
Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

2042 Eastern Avenue

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6-24-97 71

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

House wife

11. BIRTHPLACE (State or foreign country)

Maryland America

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Not known

Frank Sadowski

14. MOTHER'S MAIDEN NAME

Not known

Mary Welzant

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

212-28-6742A

17. INFORMANT

Mr. Roman A. Kaminski 3125 Eastern Ave
Sane

ADDRESS

3125 Eastern Ave
2042 Eastern Ave

18.

269.9

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Severe Dehydration

malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

286.5 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Generalized Arteriosclerosis

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

☒

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 9 19 68 to November 9 19 68, that (I) (we) last saw the deceased alive on November 9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Corazon Z. Vergara, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Nov. 9, 1968

23C. PHYSICIAN'S NAME (Type)

CORAZON Z. VERGARA, M.D.

23D. ADDRESS

Church Home Hospital
100 N. Broadway Baltimore MD 21231

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/13/68

24C. NAME of CEMETERY or CREMATORY

Holy Rosary

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 12 1968

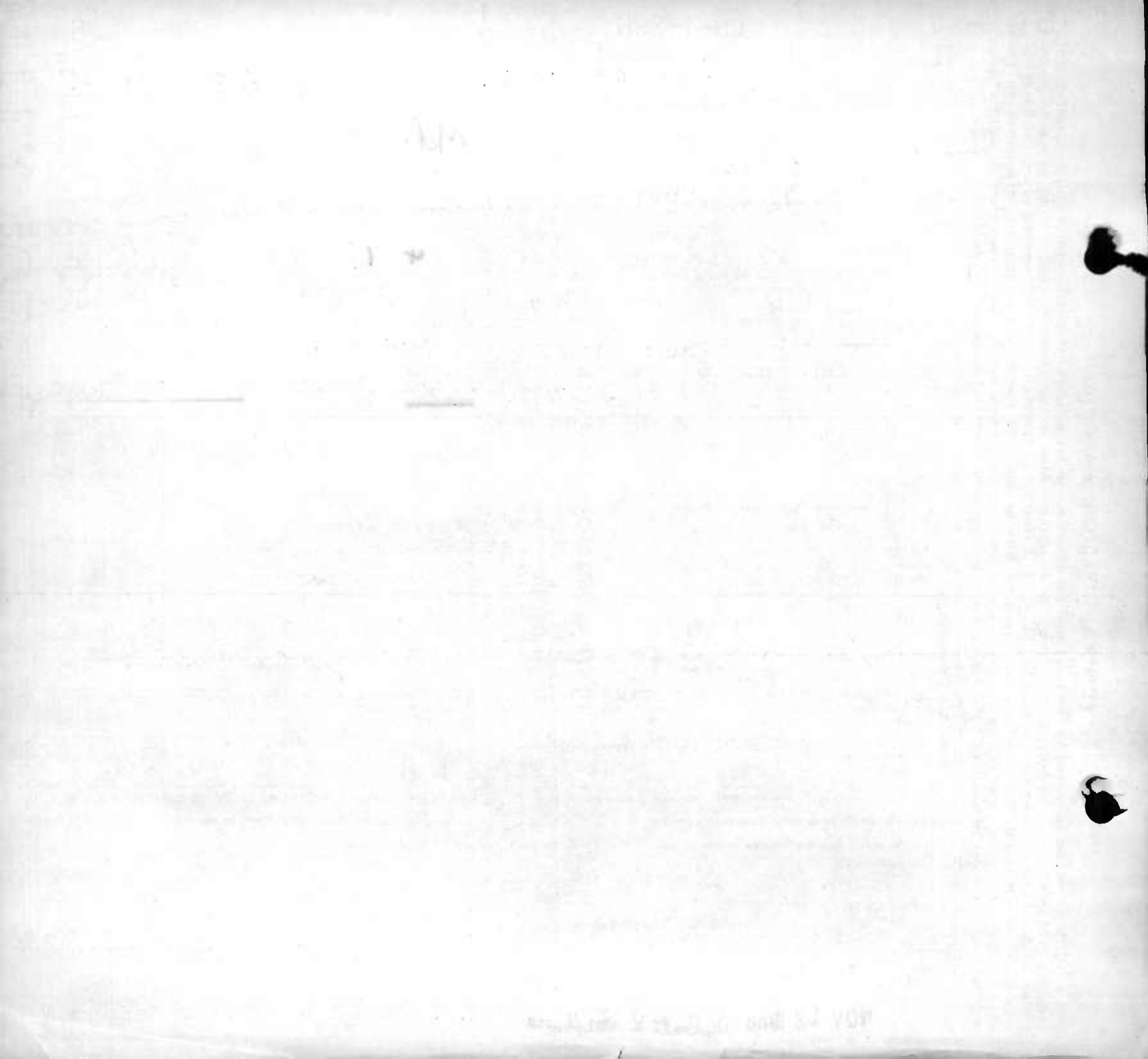
25B. NAME OF REGISTRAR

Robert E. Tschirner

25C. FUNERAL DIRECTOR

M.F. SADOWSKI & SONS, 1808 Eastern Ave

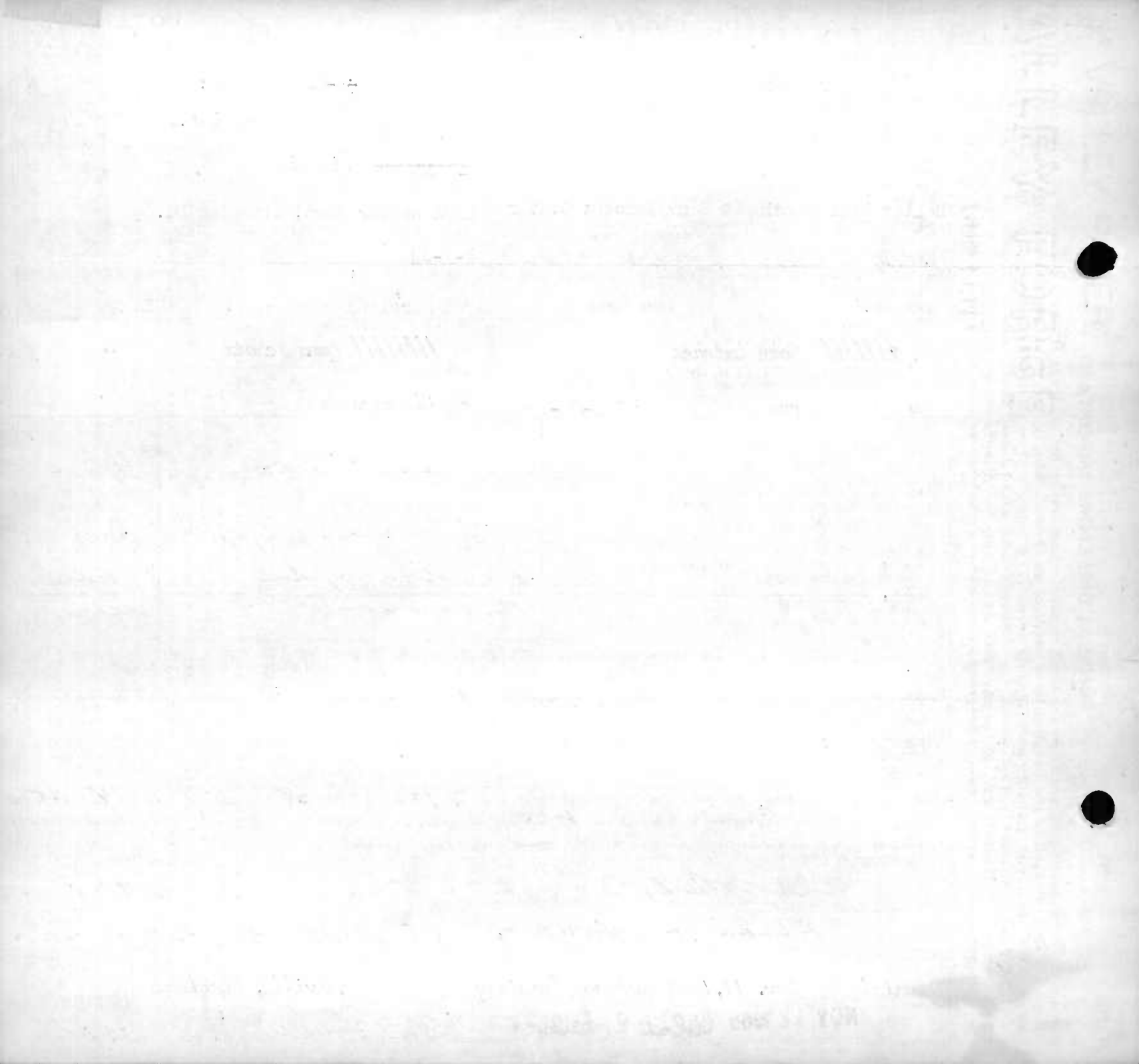
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11297
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary Smith		2. DATE AND HOUR OF DEATH 11-8-68 11:30 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing & Convalescent Center		C. CITY OR TOWN Timonium D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2104 Reuter Road, Timonium Md.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-80	9. AGE (In years last birthday) 88 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown John Latcher		
14. MOTHER'S MAIDEN NAME Unknown Emma Schott		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		
16. SOCIAL SECURITY NO. 213-05-9749		17. INFORMANT ADDRESS Family records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 43391		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis 4 hours (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis generalized years (C) DUE TO, OR AS A CONSEQUENCE OF: chronic brain syndrome years Parkinsonism years		
19. DATE OF OPERATION 332X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7/26 1968 to 11/8 1968 , that (I) (we) last saw the deceased alive on 11/8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE ALLAN H. MACHT MD		23B. DATE SIGNED 11/9/68		23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD
23D. ADDRESS 2 E READ ST Balt Md 21202		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE Nov. 11, 1968		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR John L. Burns Sons
25D. ADDRESS Lawson				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11298

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11298

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Nickens, Benjamin</i>		2. DATE AND HOUR OF DEATH <i>7¹⁵ pm 11/10/68</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Lincoln Mem Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1532 Poplar Grove St</i>	
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/20/86</i>	9. AGE (In years lost birthday) <i>82</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lancaster, Va.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>219-01-1137</i>		17. INFORMANT ADDRESS	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>C. V. A.</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>331X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/28</i> 19 <i>62</i> to <i>11/10</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>11/10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harris Sennalene</i> DEGREE				23B. DATE SIGNED <i>11/10/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harris Sennalene</i> DEGREE				23D. ADDRESS <i>1801 GREENBERN RD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/15/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT Auburn Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>Nov 12 1968</i>		25B. NAME OF REGISTRAR <i>John E. Edwards</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Adolphus Halstead 1206 W North A</i>	

Wang, Son
J. L. Wang
1000 Washington St.
Wang, Son
J. L. Wang

211-11-1111

C. V. A.

1/27 12 11/10

11/10

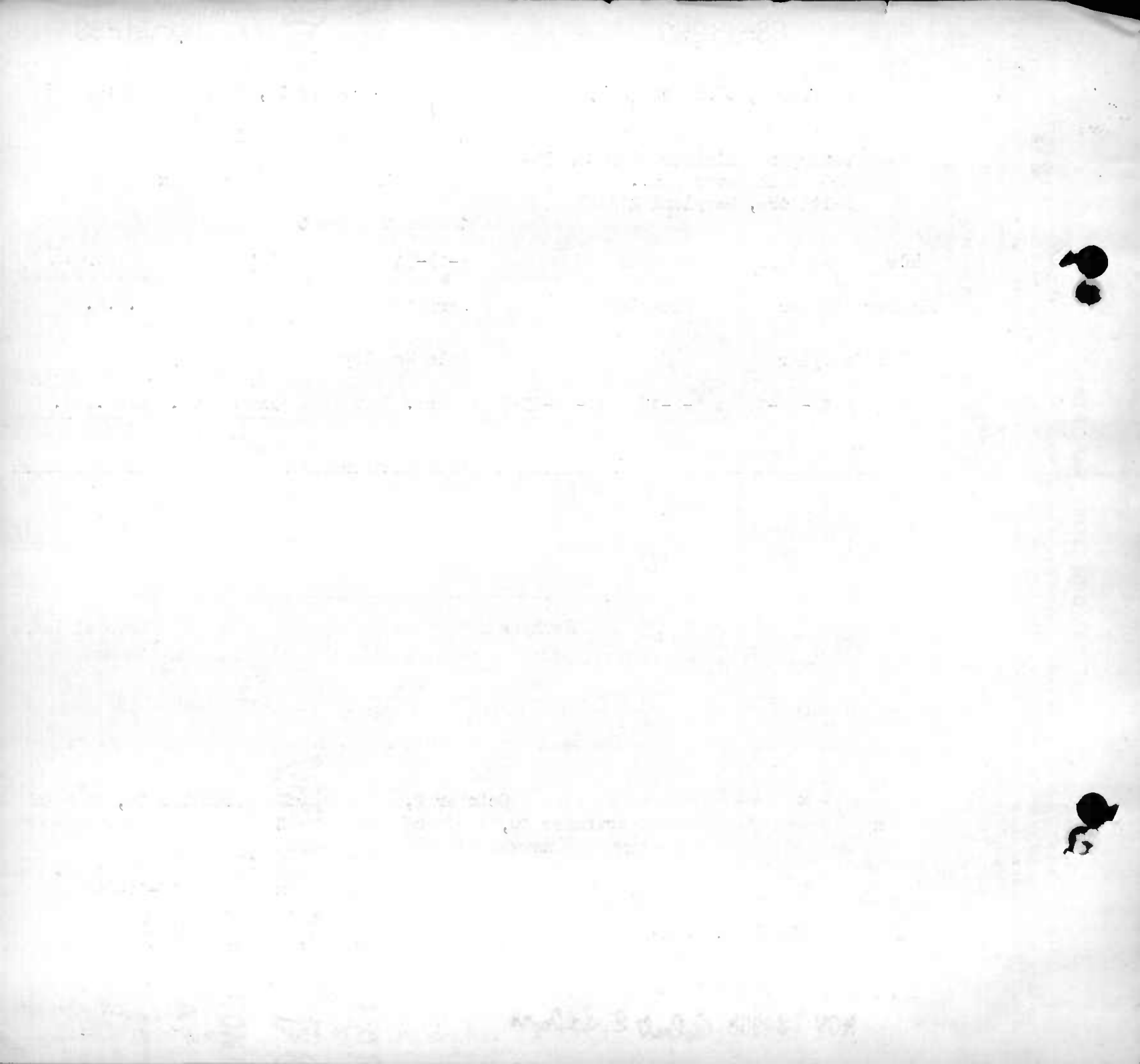
John, Jr.
John, Jr.

No. 1 Greenback

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11299	
68-11299		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		TYLER, Clarence (NMI)		November 10, 1968 3:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
		A. STATE B. COUNTY			
		Maryland Anne Arundel			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		102 South Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negroid	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5-15-94	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Plumbers Helper		Plumbing		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Charlie Tyler			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes 10-26-17 to 9-2-19		214-05-2355		Records	
				ADDRESS 21218	
				VA Hosp. 3900 Loch Raven Blvd. Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Several Days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
Emphysema				Several Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from October 2, 19 68 to November 10, 19 68, that (we) last saw the deceased alive on November 10, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
ELLIS L. JONES				11-11-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/14/68		BALTIMORE NATIONAL	
				BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 12 1968		Wm. Reese II		108 W. Washington St. Annapolis, Md.	



L-000

68-11300 BALTIMORE CITY HEALTH DEPARTMENT

68-11300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jerome Lester Lee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11, 2, 1968 9:50 PM.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11, 2, 1968 9:50 PM.	
6. SEX M		7. RACE C	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/8/49		10. AGE (In years last birthday) 19	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF USA	
13. FATHER'S NAME Charles N. Lee		14. MOTHER'S MAIDEN NAME Martha Oden	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-01		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. DATE OF BIRTH 2/8/49		17. AGE (In years last birthday) 19	
18. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		19. KIND OF BUSINESS OR INDUSTRY Unemployed	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give dates of service) No		21. SOCIAL SECURITY NO.	
22. INFORMANT Edna Parham-861 W. Lexington St.		23. ADDRESS	
19. CAUSE OF DEATH E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of head. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 981X			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Saratoga and Amity Streets	
22D. TIME OF INJURY (APPROX.) 11, 2, 1968 9:26 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot during altercation		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24. ACTUAL SIGNATURE Werner U. Spitz, M.D.		25. DATE SIGNED 11/3/1968	
26. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		27. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
28. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		29. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-68	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn AA. Co Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Thornell B. Oden - Balto. Md.		25D. ADDRESS	

Charles M. Lee
Master - Crew
Chas. M. Lee - 1861

2/8/11
H
Baltimore
Maryland
No

James M. Lee

James M. Lee
11-11-11
Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11301

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11301

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARION G. THOMAS		2. DATE AND HOUR OF DEATH 11-9-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 6-0		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY BEAUTY SALON		8. DATE OF BIRTH 2-17-1912 9. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BOWEN	
14. MOTHER'S MAIDEN NAME MILLCIENT R. WARNE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Julian H. Thomas - 2803 Jefferson St.		ADDRESS			
18. 348.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antenatal causes		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Amniontrophic lateral sclerosis		over 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. DATE OF OPERATION 356.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory arrest		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				several hrs	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 65 to death 19 68 , that (I) (was) last saw the deceased alive on Sept 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) view the body after death.					
23A. SIGNATURE Howard Moses MD		23B. DATE SIGNED 11-12-68		23C. PHYSICIAN'S NAME (Type) Howard Moses MD	
23D. ADDRESS Medical Arts Bldg Balto 21201		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-12-68	
24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Walter Miller - 2334 Jefferson St.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11302 CERTIFICATE OF DEATH

REG. NO. 68-11302

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PLATTI, ELIO FRANCIS		NOVEMBER 4, 1968 2:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				A. STATE MARYLAND B. COUNTY Hawes 20810 63-00	
				C. CITY OR TOWN LAUREL	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 910 LYON AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09/20/13	9. AGE (In years lost birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
electrical technician laboratory		John H. Hopper		NEW YORK CITY	
13. FATHER'S NAME FRANK PLATTI				14. MOTHER'S MAIDEN NAME AURILIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 2		16. SOCIAL SECURITY NO. 113-03-0222		17. INFORMANT CATON & WILKENS AVENUES ST AGNES HOSPITAL'S RECORDS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Nutritional Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3810 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 21 19 68 to NOVEMBER 4 19 68, that (X) (we) lost saw the deceased alive on NOVEMBER 4 19 68 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Charles J. Lancelotta, Jr. M.D.				23B. DATE SIGNED 11/4/68	
23C. PHYSICIAN'S NAME (Type) CHARLES J. LANCELOTTA, JR. M.D.				23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation 11-5-68		11-5-68		East Lincoln Cem	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR R. O. S. Jones		25C. FUNERAL DIRECTOR Lance M. Jones	

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BALTIMORE, MARYLAND
JAMES EARL RAY
WORLD WAR II
APRIL 1945
CITIZENSHIP
NATURALIZATION
NOV 1 1967
BALTIMORE, MARYLAND
JAMES EARL RAY
WORLD WAR II
APRIL 1945
CITIZENSHIP
NATURALIZATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11303

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BROWN MARY Pearl		2. DATE AND HOUR OF DEATH 11-11-68 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 824 WICKLOW RD.					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Johnson			14. MOTHER'S MAIDEN NAME Ida Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS David Lee 824 Wicklow Rd.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 757.0					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE CHRONIC RENAL INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION. CEREBRAL ARTERIOS DUE TO, OR AS A CONSEQUENCE OF: (C) CLEAOSIS.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 334X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-2 19 68 to 11-11 19 68 , that (I) (we) last saw the deceased alive on 11-11 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge Garcia M.D.				23B. DATE SIGNED 11-11-68	
23C. PHYSICIAN'S NAME (Type) JORGE GARCIA M.D.				23D. ADDRESS LUTHERAN HOSPITAL OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. (State) Md.			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR John R. Bailey		25C. FUNERAL DIRECTOR ADDRESS Funeral Home 1348 W. Calhoun St.	

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68-11304 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11304

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT HOWARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968 Hour 8:18 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 HOPKINS HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968 Hour 8:18 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-10-46		10. AGE (In years, months, days, hours, minutes) 22	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Howard		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
15. MOTHER'S MAIDEN NAME Lillian Land		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Shirley Howard	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E965 X CAUSE OF DEATH Gunshot wound of Chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E981 X		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. DATE OF OPERATION	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) yes	
25. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Book Store	
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 624 N. Castle Street		28. TIME (Month) (Day) (Year) (Hour) Nov. 8, 1968 7:55 P.m.	
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		30. HOW DID INJURY OCCUR? Shot by store owner	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED November 9, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-13-68	
24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Kelson F. H.	
25C. FUNERAL DIRECTOR V.R. Bailey		25D. ADDRESS 1348 Calhoun St.	

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68-11305 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11305

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM RIDGELY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 9, 1968 2:55 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 720 N. Mount Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 9, 1968 2:55 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-23-94		10. AGE (In years lost birthday) 74	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217036710	
18. INFORMANT Catherine Martin		ADDRESS same	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 10, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-15-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Kelson F. H.		25D. ADDRESS 1248 Calhoun Street	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11306 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11306

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Diggs, Humphrey Silas Jr.		2. DATE AND HOUR OF DEATH November 10, 1968 4:45A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 15-12			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-30-97	
13. FATHER'S NAME Humphrey S. Diggs		14. MOTHER'S MAIDEN NAME Margaret Thomas		9. AGE (In years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/27/17 to 6/18/19		16. SOCIAL SECURITY NO. 223-10-84-28		11. BIRTHPLACE (State or foreign country) virginia	
				12. CITIZEN OF WHAT COUNTRY? United States	
				17. INFORMANT ADDRESS Veterans Hospital Records 3900 Loch Raven Blvd., Balto., Md. 21218	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immediate (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 465X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from Oct 28, 1968 to Nov. 10, 1968 , that (X) (we) lost saw the deceased alive on Nov. 10, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.					
23A. SIGNATURE Ruth Ann Prybylski, M.D. DEGREE				23B. DATE SIGNED Nov. 10, 1968	
23C. PHYSICIAN'S NAME (Type) RUTH ANN PRYBYSZ DEGREE				23D. ADDRESS Veterans Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME of CEMETERY or CREMATORY Church Cem.	
24D. LOCATION Gloucester Co., Va.		24E. DATE REC'D BY HEALTH DEPT. NOV 12 1968		24F. NAME OF REGISTRAR Robert E. Bailey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR V.R. Bailey Kelson F. H. 1348 N. Calhoun St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11307

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Linda Elithia Jackson

2. DATE AND HOUR OF DEATH

Nov. 8, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

US Public Health Service Hospital
3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Pa.

C. CITY OR TOWN
West Grove

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

151 Rose Hill Avenue

5. SEX

F

6. RACE

Col.

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4/11/58

9. AGE (In years
lost birthday)

10

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Jackson

14. MOTHER'S MAIDEN NAME

HELEN LEWIS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

1B.

204.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) slowing the
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 min

(B) Acute lymphocytic leukemia

DUE TO, OR AS A CONSEQUENCE OF:

(C)

204.3 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from June 10 1968 to Nov. 8 1968,
that (1) (we) last saw the deceased alive on Nov. 8 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Victor S. Schneider, M.D.

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

11/8/68

23C. PHYSICIAN'S
NAME (Type)

VICTOR S. SCHNEIDER MD

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/12/68

24C. NAME OF CEMETERY or CREMATORY

New London Pres. Cem.

24D. LOCATION

(City, town, or county)

(State)

New London Twp. Chester, Pa.

25A. DATE RECEIVED BY HEALTH DEPT.

NOV 12 1968

25B. NAME OF REGISTRAR

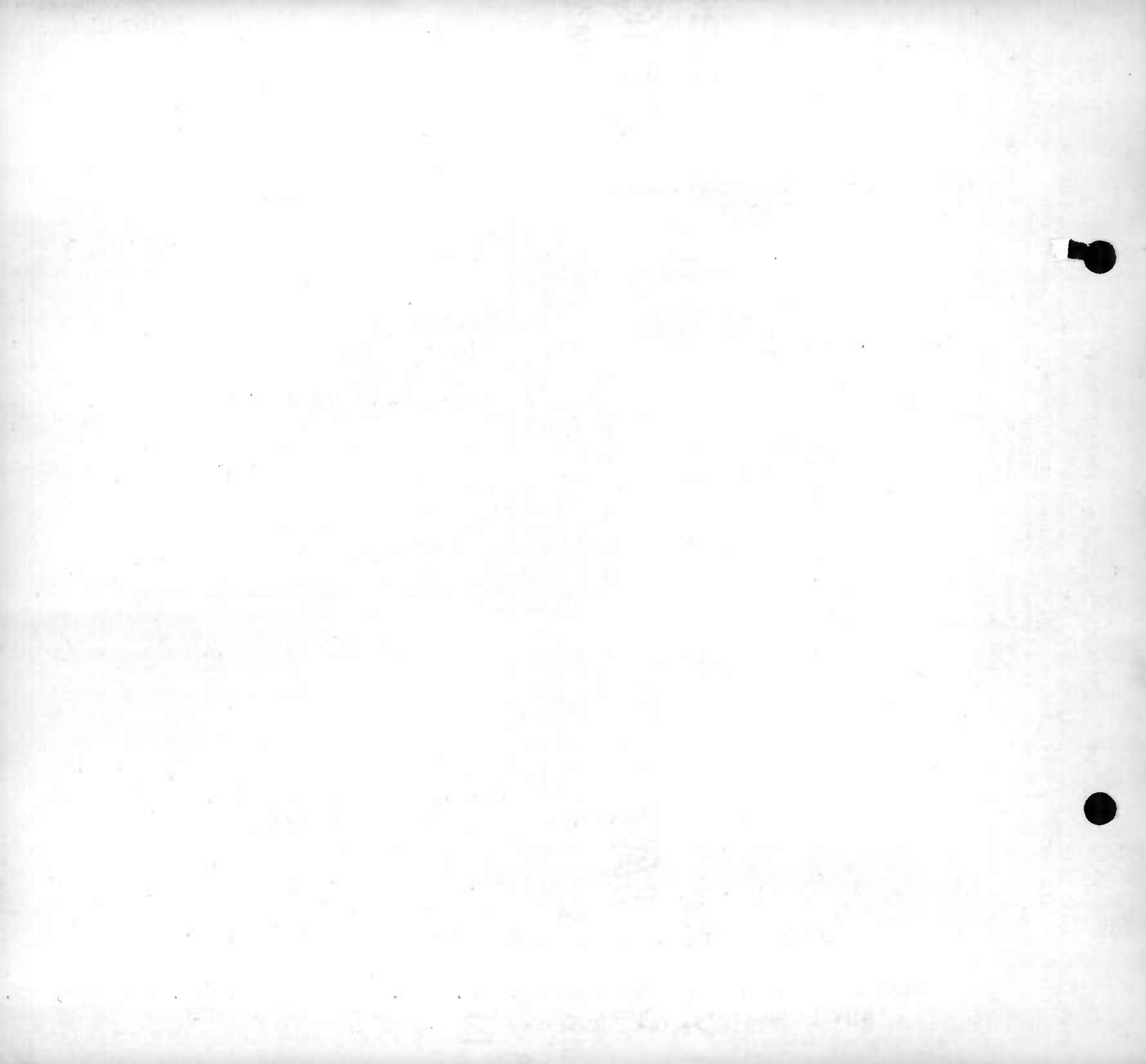
Robert E. Jackson

25C. FUNERAL DIRECTOR

Kelton F. H.

ADDRESS

1348 N. Calhoun St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11308

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY STEWART		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 9, 1968 Hour 7:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1005 N. Dukeland Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 9, 1968 Hour 7:30 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-28-33		10. AGE (In years lost birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME John Martin		15. MOTHER'S MAIDEN NAME Helen Stewart	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Helen Jones		ADDRESS same	
19. 5-7-8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty Metamorphosis of Liver		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. 5-8-0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> November 9, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Sisk	
25C. FUNERAL DIRECTOR V.R. Bailey		ADDRESS Kelson F.H. 1348 N. Calhoun St.	

9-28-33

U.S.

U.S.

John Martin

John Martin

John Martin

no

John Martin

WALLBURY

WALLBURY

WALLBURY

John Martin

John Martin

John Martin

John Martin

John Martin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11309 CERTIFICATE OF DEATH

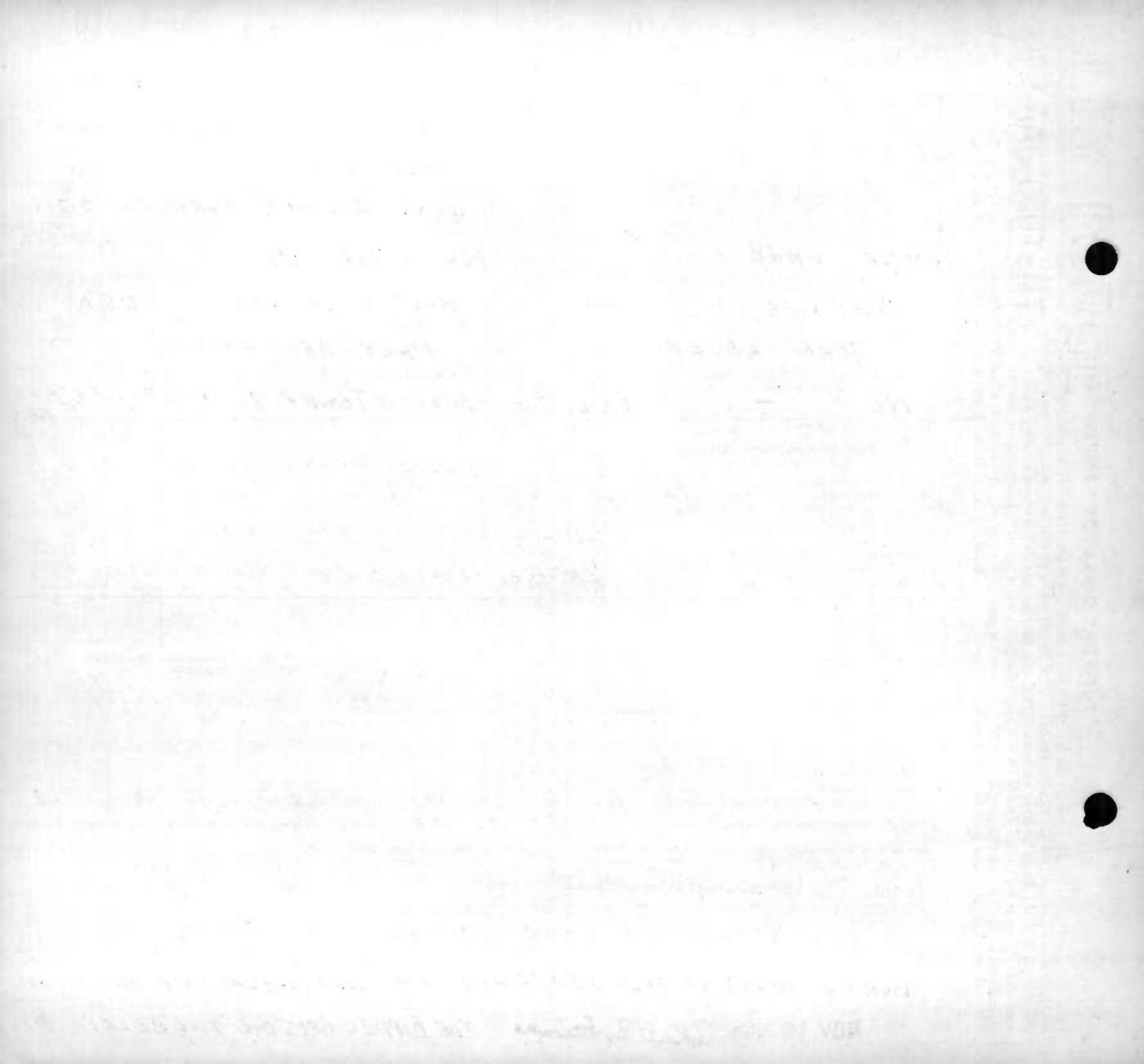
REG. NO. 68-11309

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOMSHER JOHN G.		2. DATE AND HOUR OF DEATH 11. 10. 68 10-45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE ✓ MARYLAND B. COUNTY 1-04	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL				C. CITY OR TOWN ✓ BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2640 Hudson St #24					
5. SEX m	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1915	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER PAINTER CONTINENTAL CAN CO		10B. KIND OF BUSINESS OR INDUSTRY LANCASTER PA.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME ELMER THERAN HOMSHER			14. MOTHER'S MAIDEN NAME SARAH LOUISE EVANS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 188-05-3948		17. INFORMANT ADDRESS MRS Louise 2640 Hudson St #24	
18. 303.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Central Respiratory failure A.U.A. chronic alcohol ? Parathyroid adenoma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 322.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11. 9. 1968 to 11. 10. 1968 , that (I) (we) last saw the deceased alive on 11. 10. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mesbah Uddin				23B. DATE SIGNED 10. 11. 68	
23C. PHYSICIAN'S NAME (Type) MESBAH UDDIN - MD				23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 13 1968		24C. NAME OF CEMETERY or CREMATORY MEADOW RIDGE MEMORIAL PK WASHINGTON BLVD DORSET MD	
24D. LOCATION (City, town, or county) (State) MD					
25A. DATE RECEIVED NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Sweeney		25C. FUNERAL DIRECTOR ADDRESS THE DIPPEL BROS INC 1800 E LOMBARD ST	

FUNERAL DIRECTOR: IMPORTANT

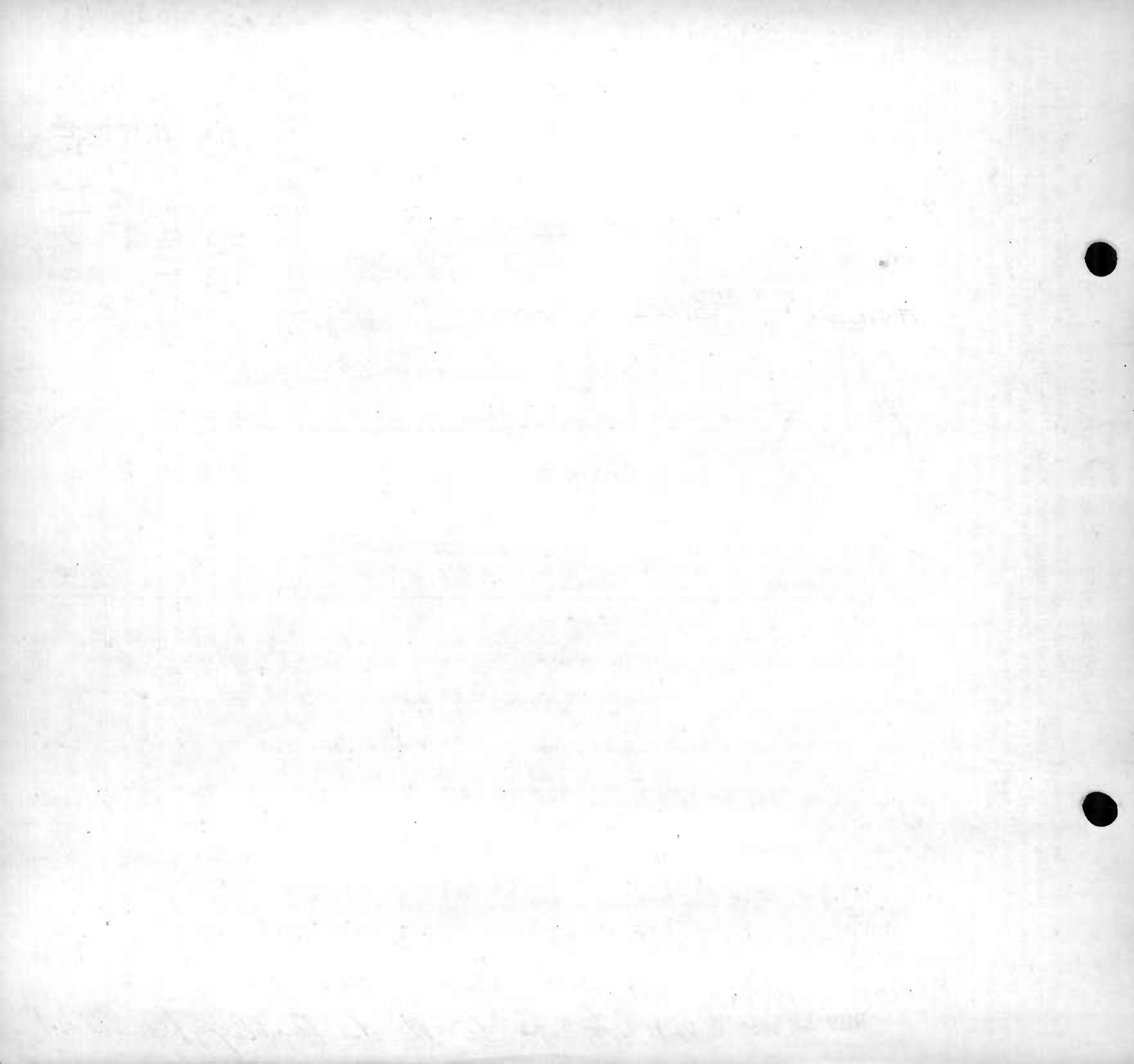
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-00001		68-11310		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11310	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) TEWEY AGNES CATHERINE		2. DATE AND HOUR OF DEATH 11-10-1968 6:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY BALTIMORE 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL				C. CITY OR TOWN BELMAR		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 4302 BELMAR AVENUE 21206			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 29 1898		9. AGE (In years lost birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN LAUER				14. MOTHER'S MAIDEN NAME MARY HENNEMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO —		16. SOCIAL SECURITY NO. 705-05-7401		17. INFORMANT EDWARD J TEWEY		ADDRESS 8654 NOERNER AVE 21224	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE CORONARY OCCLUSION ATHEROSCLERATIC CARDIOVASCULAR DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 420.1 II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 11-10-1968 to 11-10-1968 , that (H) (we) last saw the deceased alive on 11-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death.							
23A. SIGNATURE Joseph Notarangelo M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-11-1968	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.				23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 13 1968		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEM.		24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR THE DYPPLE BROS INC		ADDRESS 110 BELAIR RD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made to death. Such

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11312	
BIRTH NO. 68-11312		LADANYI			
1. NAME OF DECEASED (Type or Print) ZIGMOND LADANYI		2. DATE AND HOUR OF DEATH 11/10/68 7:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. 21224		C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-01-96		9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIN PLATE HANDLER		10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH LADANYI		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 282-07-3937		17. INFORMANT ADDRESS BCH RECORDS: 4940 EASTERN AVE. 21224	
18. 4120 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR ARRHYTHMIAS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) HYPOKALEMIA		2 weeks	
		(C) HCV D + ASCVD		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 443X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 8 19 68 to Nov. 10 19 68, that (I) (we) last saw the deceased alive on Nov. 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Kaplan MD		23B. DATE SIGNED 11/10/68		23C. PHYSICIAN'S NAME (Type) JOSEPH KAPLAN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/14/68		24C. NAME OF CEMETERY OR CREMATORY GRDNS. FAITH	
24D. LOCATION (City, town, or county) BALTO. CO. MD.		24E. NAME OF REGISTRAR Robert E. Johnson		24F. FUNERAL DIRECTOR W. Dunbar Buckley Dundalk, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

LAURENCE H. HARRIS

HARRIS

W. L. HARRIS

W.

W. L. HARRIS

W. L. HARRIS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11313

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEO COUNTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> November 10, 1968 3:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1204 E. Preston St. (Midway Service Sta.)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 10, 1968 3:45 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-09			
6. SEX male	7. RACE negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH April 8th 1940		10. AGE (In years lost birthday) 28	E. STREET AND NUMBER 1020 E. Oliver St.
11. BIRTHPLACE (State or foreign country) Chapel Hill, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Leo Counts Sr.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Evelyn Koone
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Evelyn Koone 2018 E. Eager St.
19. E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Gunshot Wounds (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. E 981 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) service station	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1204 E. Preston St. (midway service station)		22D. TIME OF INJURY (APPROX.) 11/10/68 3:30 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. was shot during an attempted holdup	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 11/11/68	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 11-15-68	24C. NAME of CEMETERY or CREMATORY MT. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore Md
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968	25B. NAME OF REGISTRAR R. E. F. F.	25C. FUNERAL DIRECTOR Gray & White	ADDRESS 1000 Broadway

April 1946

Chapman, S. C.

11-10-46

See page 10

Exhibit 10

Exhibit 10

WILLIAM

ROBERTSON

11-10-46

Exhibit 10

Exhibit 10

11-10-46

NOV 1946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11314

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT LINN BROWN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 7, 1968

8:02 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)

44 Union Memorial Hospital

2-11-69

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 7, 1968

8:02 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

July 16, 1916

10. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

346 East 28th Street

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alex Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Vella Walker

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Rosella Brown Sauer

ADDRESS

19. 412.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Intestinal hemorrhage

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.443X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 7, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-12-68

24C. NAME OF CEMETERY or CREMATORY

High Rock, Ga.

24D. LOCATION (City, town, or county)

North Carolina

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 12 1968

25B. NAME OF REGISTRAR

Robert E. Springate

25C. FUNERAL DIRECTOR

H. J. Wilson

ADDRESS

Marriage Record of Deceased and Widow's
Affidavit 2-11-69 M.H.

VALLEY FORCE

25% HAD CONTENT

47

CERILL

AD

11-2

11-2

9

11-2

11-2

11-2

11-2

68-11315

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11315

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VERNON BANKS

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

November 8, 1968

4:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 8, 1968

4:30 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male7. RACE
Negro8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 18, 1927

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

421 N. Chapel Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Banks

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Kara Brown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

214-28-7525

18. INFORMANT

ADDRESS

19. 5-77.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Pancreatitis

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

387.2 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

(C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 9, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-12-68

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Baltimore Md

25A. DATE RECD BY HEALTH DEPT.

NOV 12 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

E. Henry B. Wilson, 1000 Rutledge

ADDRESS

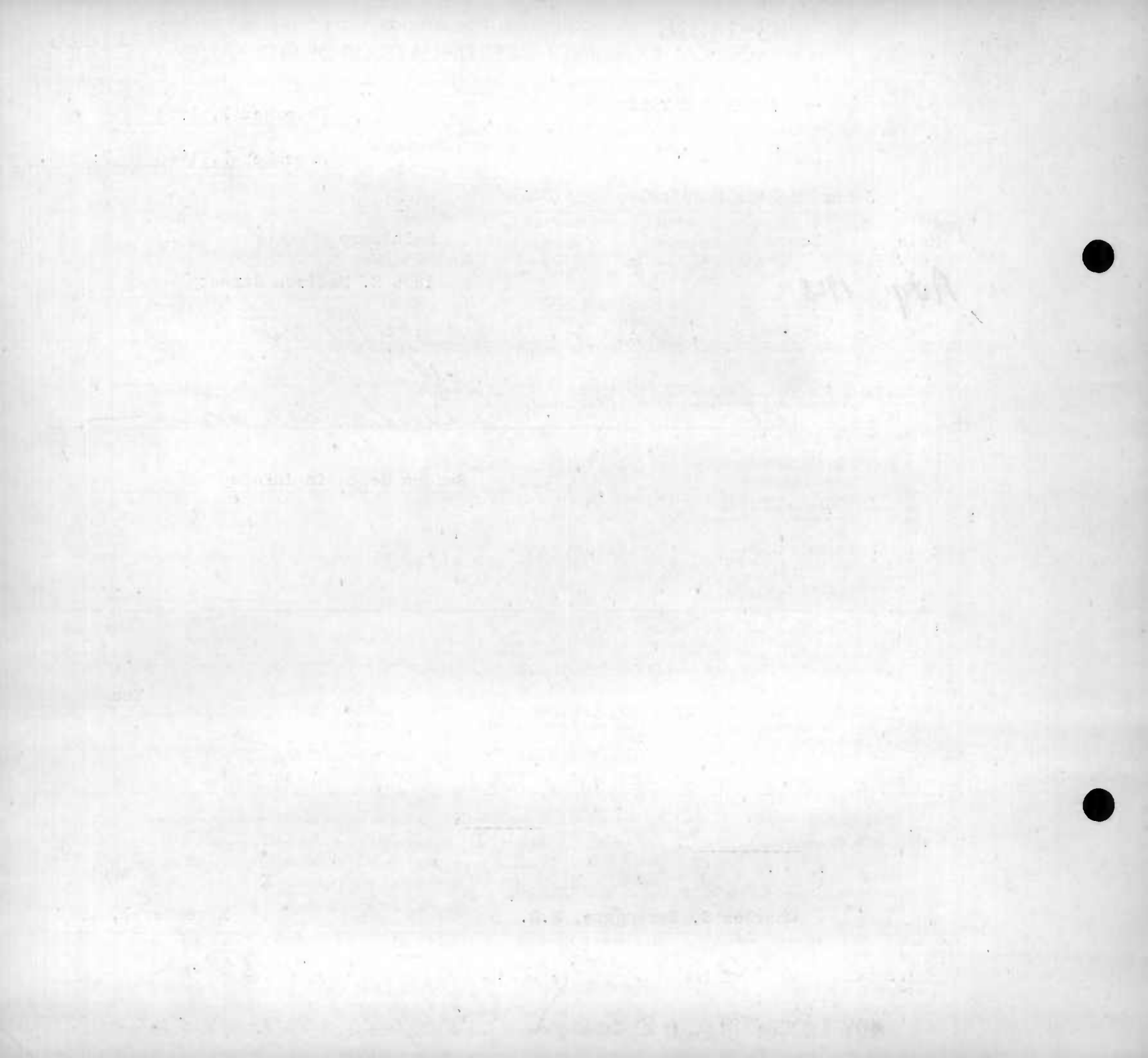
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11316

BIRTH NO. 68-12914

REG. NO.

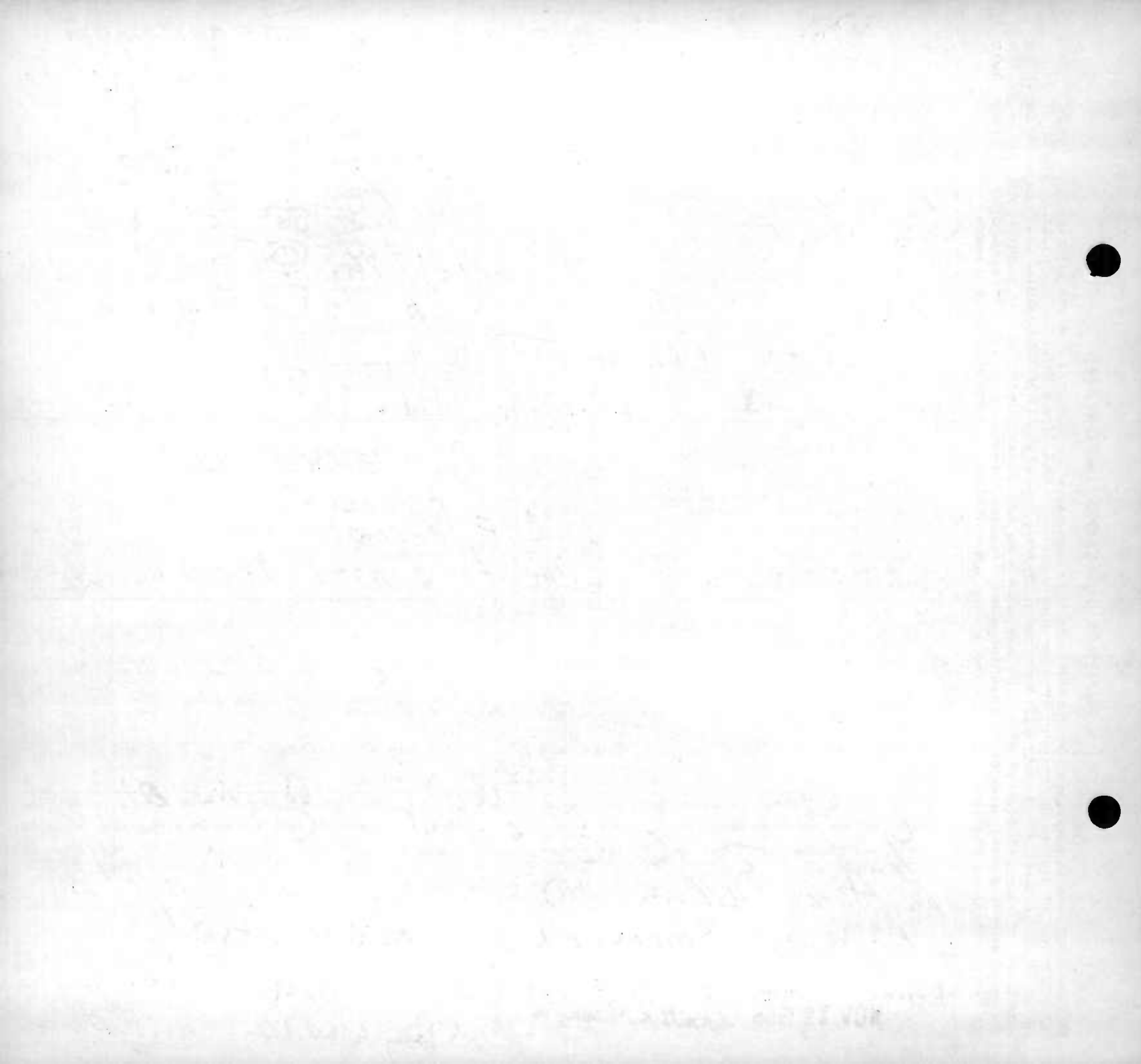
1. NAME OF DECEASED (Type or Print) ANDRE WATERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 7, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 7, 1968 7:15 A.M.	
6. SEX Male	7. RACE Negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Autg. 1968		10. AGE (In years, last birthday) 3 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTH PLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vernon Waters		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Julia Samuels		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Julia Samuels	
19. 795X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 795-2 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sudden death in infancy	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. AUTOPSY? (Yes or No) Yes	
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		28. HOW DID INJURY OCCUR?	
29. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Min.)		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
32. ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		33. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
34. DATE SIGNED November 7, 1968		35. DATE SIGNED	
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 11-9-68	
38. NAME OF CEMETERY or CREMATORY Mt Airy		39. LOCATION (City, town, or county) (State) Baltimore Md	
40. DATE REC'D BY HEALTH DEPT. NOV 12 1968		41. NAME OF REGISTRAR Robert S. Johnson	
42. FUNERAL DIRECTOR Clay Wilson		43. ADDRESS 1000 B. Smith St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 08-11317				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11317	
1. NAME OF DECEASED (Type or Print) SAMUEL CORBETT				2. DATE AND HOUR OF DEATH 3 30 AM Nov 8th 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MERCY HOSP.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 9-28			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MERCY HOSP.				C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1906 HOMewood AVE							
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refused		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN CORBETT				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 215-12-5171		17. INFORMANT Addie Thomas		ADDRESS 1906 Homewood Ave	
18. 425X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PULM. EMBOLI, MULT				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF RECURRENT			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC				(B) DUE TO, OR AS A CONSEQUENCE OF: CARDIOMYOPATHY, IDIOPATHIC YEARS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 431X II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 68 to Nov 8th 1968 , that (I) (we) last saw the deceased alive on Nov 8 1968 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Susan Bollinger MD				23B. DATE SIGNED 11/8/68			
23C. PHYSICIAN'S NAME (Type) M. SUSAN BOLLINGER		23D. ADDRESS MERCY HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-13-68	24C. NAME of CEMETERY or CREMATORY Balt. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE RECOVERED BY THE DEPT. NOV 12 1968		25B. NAME of RECOVERING AGENT Robert E. Williams		25C. FUNERAL DIRECTOR Ernest B. Williams ADDRESS 1006 Baltimore Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11318	
BIRTH NO.		68-11318			
1. NAME OF DECEASED (Type or Print) Mary E. Hall		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY 3-01		2. DATE AND HOUR OF DEATH 10-28-68 12:00 Noon	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-27-31		9. AGE (In years last birthday) 38		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 245-10-5912		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS 4940 EASTERN AVE #21224	
18. 269.9-303.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Severe malnutrition (C) Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10-20-1968 to 10-28-1968 , that (I) (we) last saw the deceased alive on 10-28-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ronald G Michels MD DEGREE	
23B. DATE SIGNED 10-28-1968		23C. PHYSICIAN'S NAME (Type) Ronald G Michels DEGREE		23D. ADDRESS BALTIMORE BOARD OF HEALTH	
24A. BURIAL CREMATION, REMOVAL (Specify) 11/7/68		24B. DATE		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.		68-113197	
BIRTH NO. 68-20674				68-113197			
1. NAME OF DECEASED (Type or Print) BABY BOY BRITTAIN				2. DATE AND HOUR OF DEATH 11-1-68 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER BOX # 655 ROUTE 10			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-68	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RONNIE BRITTAIN				14. MOTHER'S MAIDEN NAME MARTINA SUE BROS BOX 655 RT.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 10			
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 773.5 II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 10/31/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? NO (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6:45 PM 10/31/68 to 11:20 AM 11/1/68 , that (I) (we) last saw the deceased alive on 11 AM 11/1/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE ALVIN STAMBLER MD				23B. DATE SIGNED 11-1-68			
23C. PHYSICIAN'S NAME (Type) ALVIN STAMBLER MD				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) 11-6-68		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			

Box 100 - 100

10-21-12

General

10-21-12

General

General

10-21-12

General

General

FUNERAL DIRECTOR: IMPORTANT

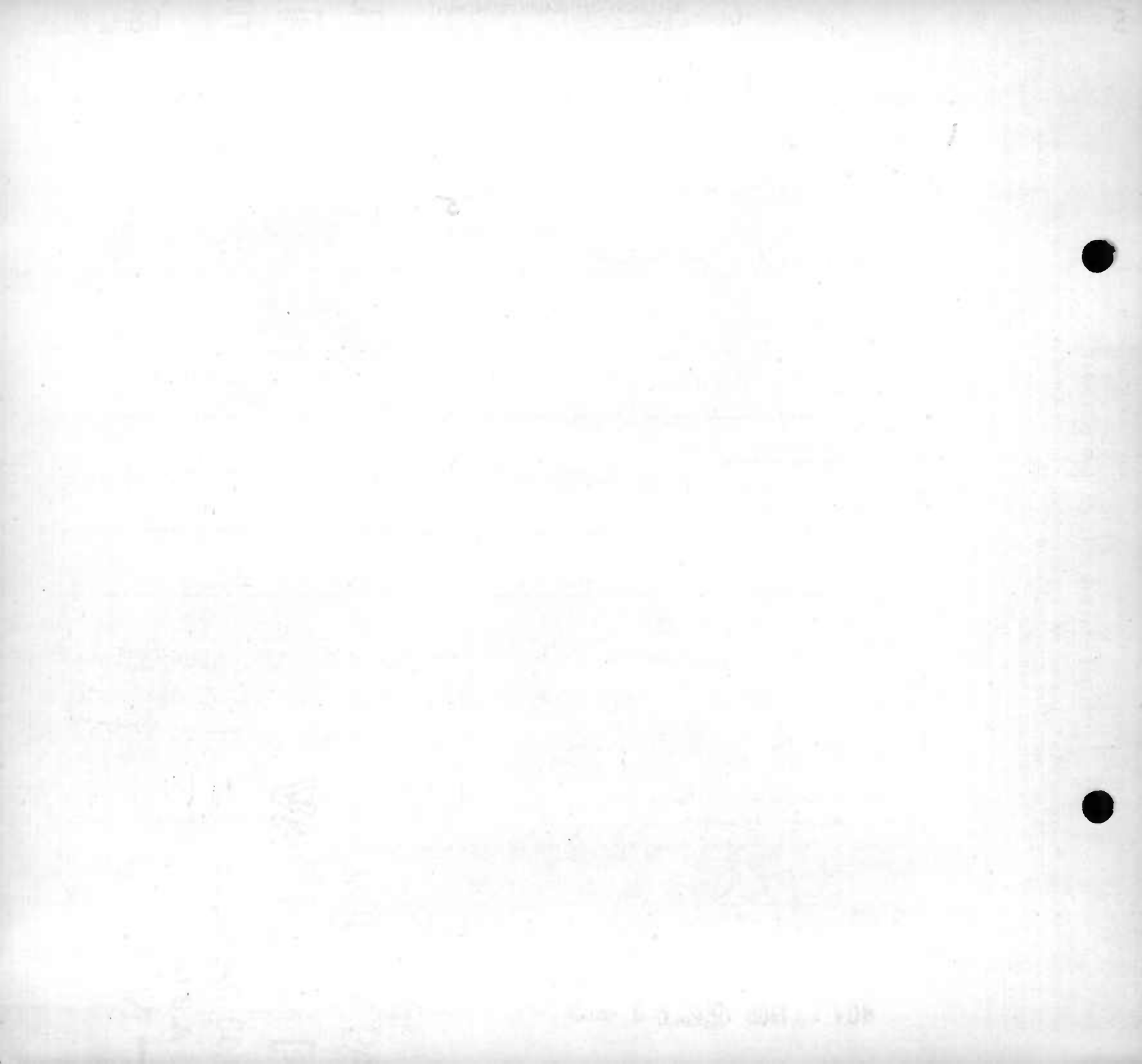
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11320 4
BIRTH NO. 68-20784		68-11320		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Boy Williams		2. DATE AND HOUR OF DEATH 8:05 AM 11/2/68			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balt. City			
		C. CITY OR TOWN City		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1733 Carroll St			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/68	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.
		11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Augustus Williams		14. MOTHER'S MAIDEN NAME DORA Glen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N.A.		16. SOCIAL SECURITY NO.	17. INFORMANT Hosp. Chest		
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Prematurely (620gm.) (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH C.S.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 774X II					
19A. DATE OF OPERATION 0 N.A.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/2/68 to 11/2/68 and that (I) (we) last saw the deceased alive on 11/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Schwarz M.D.				23B. DATE SIGNED 11/2/68	
23C. PHYSICIAN'S NAME (Type) Milton D. Schwarz M.D.				23D. ADDRESS 2526 S. Baltimore Rd. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/3/68		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
68-11321				68-11321
CERTIFICATE OF DEATH				
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>MARY I. SHAEFFER</i>		11/19/68 6P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hospital of Maryland</i>		A. STATE <i>Maryland</i> B. COUNTY <i>26-03</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>Female</i> 6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>9/1/85</i>		9. AGE (In years last birthday) <i>83</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Pobbletts</i>		
14. MOTHER'S MAIDEN NAME <i>Mary E. Jones</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mildred M. Shaeffer</i> ADDRESS <i>From chart above</i>		
18. <i>436.9 I</i>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>C. V. A</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> 19 <i>68</i> to <i>11/19/68</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/19</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>C. S. Ming</i>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <i>CHEE SHWE MING</i>				23D. ADDRESS <i>Lutheran Hospital of Maryland</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/13/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Western Cemetery</i>
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 13 1968</i>		
25B. NAME OF REGISTRAR <i>John E. Schimunek</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		
25D. ADDRESS <i>3331 Brehms Lane</i>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11322 CERTIFICATE OF DEATH

REG. NO.

68-11322

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEWIS Mr. NORMAN HENRY

2. DATE AND HOUR OF DEATH

November 9, 1968. 10.50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD. Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2728 Ashland Ave 21205

5. SEX

Male

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3.27.97

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Police

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

MD, Baltimore

12. CITIZEN OF WHAT COUNTRY?

American

13. FATHER'S NAME

John Lewis

14. MOTHER'S MAIDEN NAME

Mary ~~Oakes~~ Oakes

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

Navy WW 1

16. SOCIAL SECURITY NO.

220-38-5446

17. INFORMANT

(nee Friese)

ADDRESS

Katherine Lewis wife Same as his

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

cardiovascular failure
stroke

(B)

DUE TO, OR AS A CONSEQUENCE OF:

myocardial infarction

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-4 1968 to 11-9 1968.

that (I) (we) last saw the deceased alive on 11-9 1968 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Mier Jr.

OEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11-9-68

23C. PHYSICIAN'S NAME (Type)

Jose MIER JR. M.D.

DEGREE

23D. ADDRESS

Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/13/68

24C. NAME of CEMETERY or CREMATORY

Balto. Nat. Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

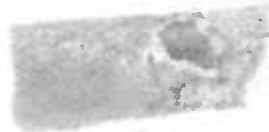
Robert E. Jenkins

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601 E. Madison St.



29

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

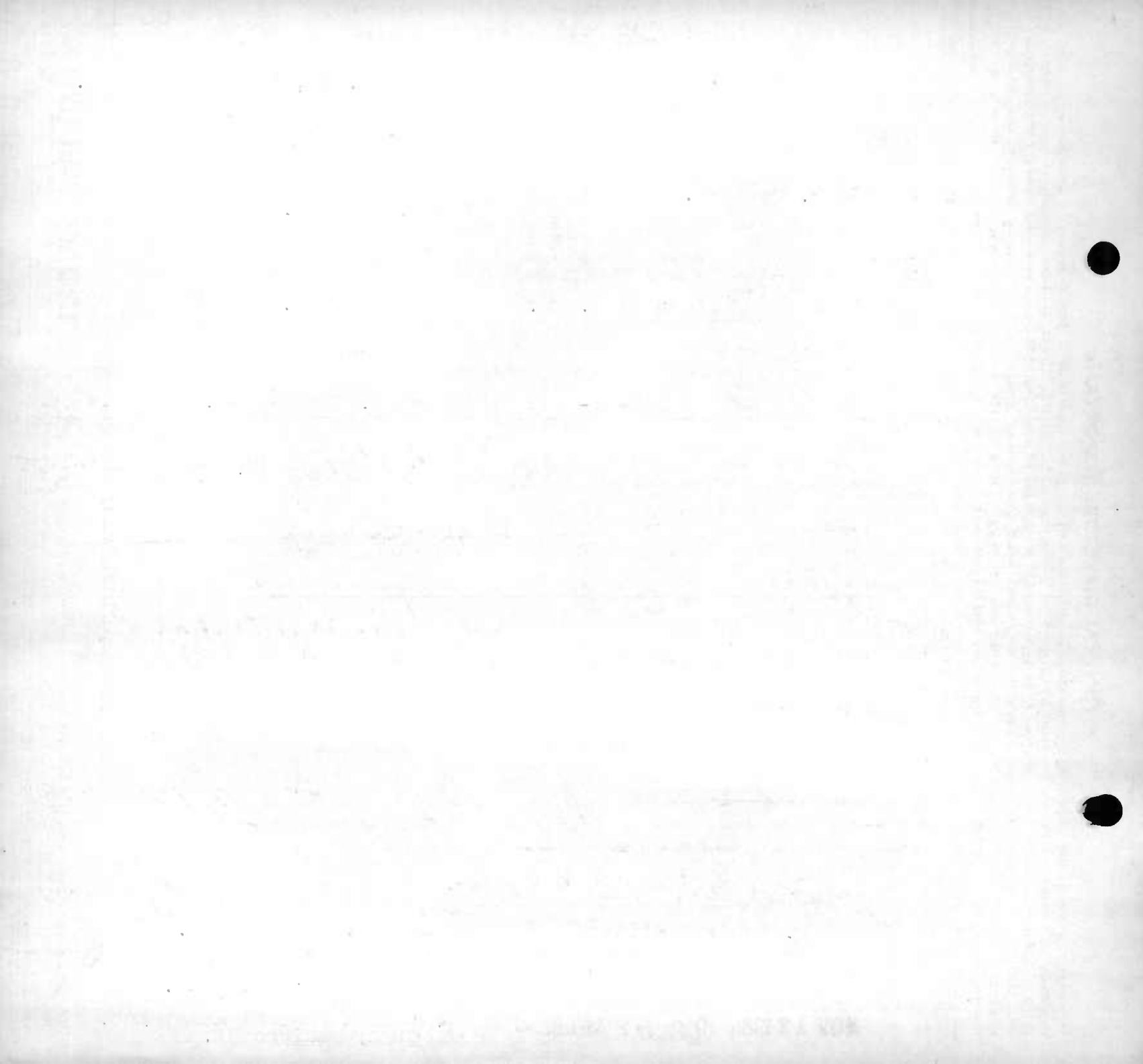
BALTIMORE CITY HEALTH DEPARTMENT

68-11323 CERTIFICATE OF DEATH

REG. NO.

68-11323

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANN J. THOMAS		Nov. 10, 1968 8 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 700 N. Port St.			A. STATE Md., 21205 B. COUNTY 7-02		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 700 N. Port St.		
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/13/1918	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Western Elec. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frank Shole			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-07-5795		17. INFORMANT Michael J. Thomas, Sr. husband, above	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastasis - lung</i> <i>Ca - cervix</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29mo. ?	
19. 17 IX II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Cardiac Hypertrophy		?	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/30 1968 to 11/10 1968, that (I) (was) lost saw the deceased alive on 11/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Louis F. Klimes</i>			23B. DATE SIGNED 11/12/68		23C. PHYSICIAN'S NAME (Type) Dr. Louis F. Klimes
23D. ADDRESS 2623 E. Monument St.			23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/13/68	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968	25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>	25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.			



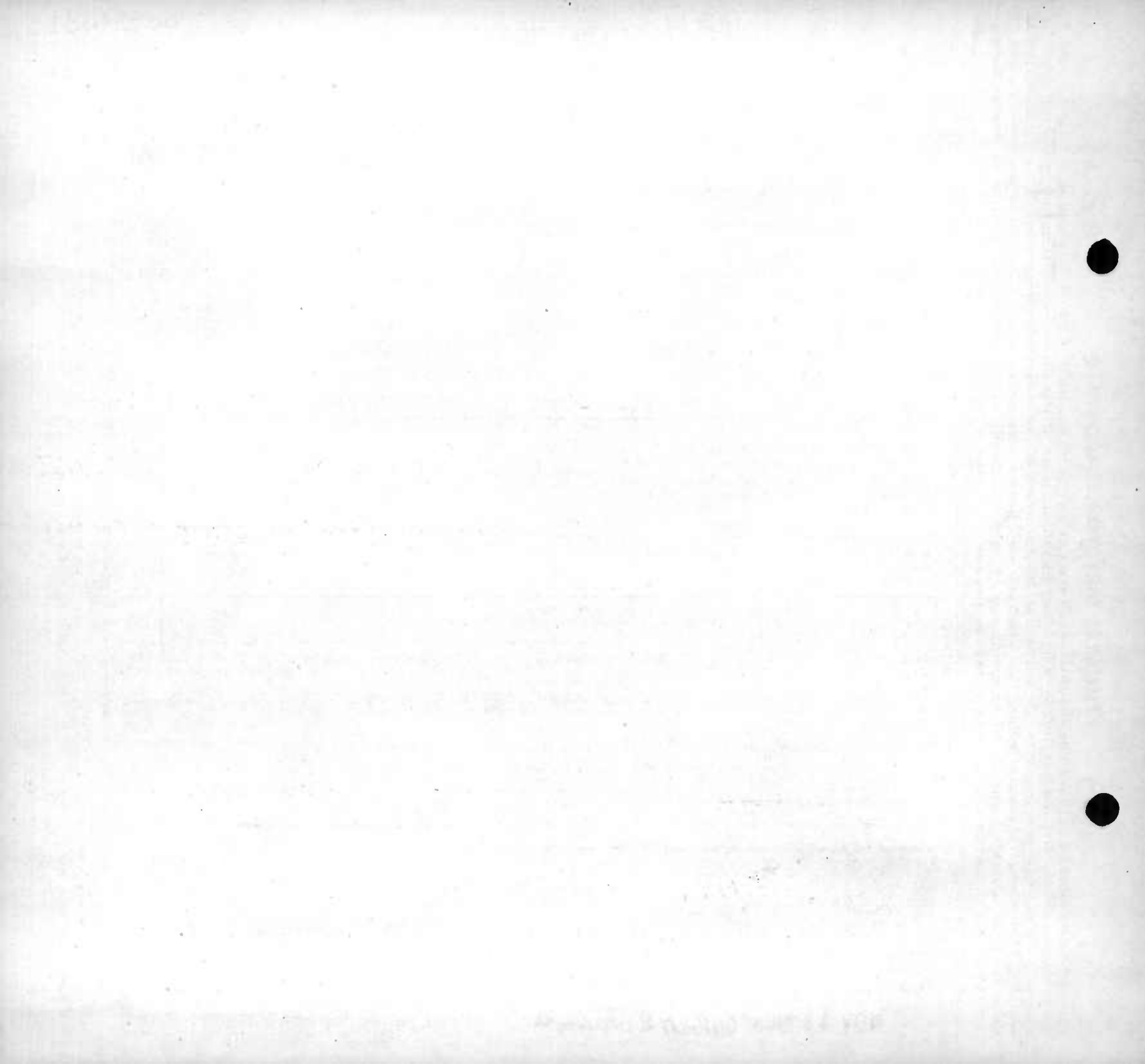
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11324 CERTIFICATE OF DEATH

REG. NO. **68-11324**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM ALBERT WEIDNER		2. DATE AND HOUR OF DEATH Nov 11, 1968 1 p. ²⁵ M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., B. COUNTY 21205 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 911 N. Belnord Avenue	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/99	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY McInnis Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frederick Weidner			14. MOTHER'S MAIDEN NAME Julia Reichert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-01-5887		17. INFORMANT ADDRESS Elsie Sherman Weidner, wife, above	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 416X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Failure (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH long duration 1 day	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/31/63 to 11/11/68 , that (I) (we) last saw the deceased alive on 10/30/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Louis C. Klimes OEGREE				23B. DATE SIGNED 11/12/68	
23C. PHYSICIAN'S NAME (Type) Dr. Louis C. Klimes		23D. ADDRESS 2623 E. Monument St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Schimunek		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11325 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11325

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES SAPPE

2. DATE AND HOUR OF DEATH

Nov. 10, 1968

2 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Gould Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

52-00

C. CITY OR TOWN

Severna Park

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

10 Cindy Court

5. SEX

male

6. RACE

white

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10/6/77

9. AGE (In years last birthday)

91

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ret-Musician

10B. KIND OF BUSINESS OR INDUSTRY

Palace Theatre

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vaclav Sappe

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-16-5305

17. INFORMANT ADDRESS Rt. 4, Cape St. Clair, Annapolis, Md.

Dr. Milton Sappe, son, 1072 River Bay Rd

18. 427.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Acute Pulmonary Edema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

12 hours

(B) DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

5 days

(C) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Congestive Heart Failure

434.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/27/19 68 to 11/10/19 68, that (I) lost saw the deceased alive on 11/8/19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Dr. Albert B. Bradley

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/11/68

23D. ADDRESS

4900 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/13/68

24C. NAME of CEMETERY or CREMATORY

Bohemian National Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

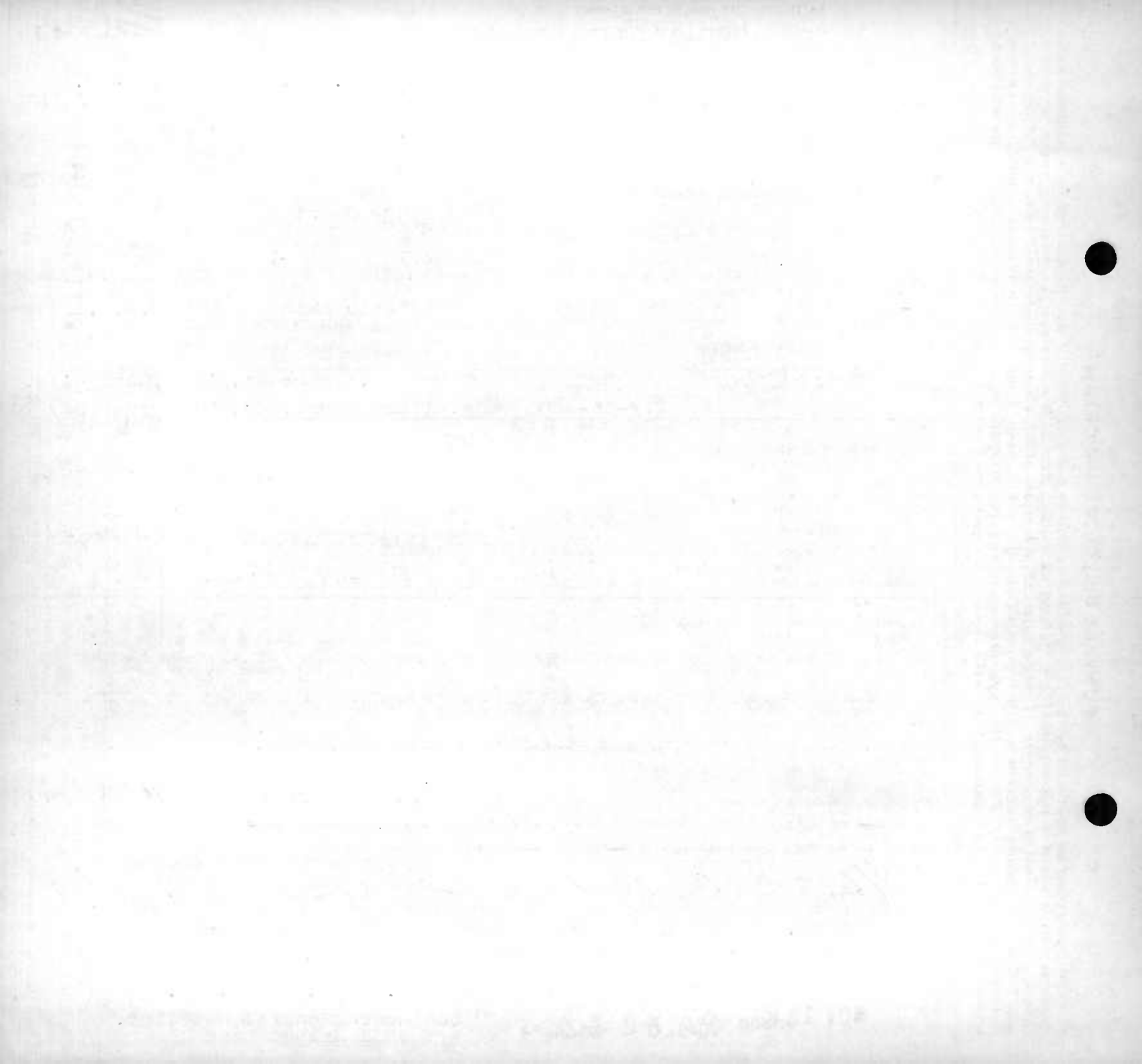
Robert E. Taylor

25C. FUNERAL DIRECTOR

Schamunek Funeral Home, Inc.

ADDRESS

3331 Brehms Land



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11327 CERTIFICATE OF DEATH

REG. NO. 68-11327

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGUERITE C. LEIMKUHLER		2. DATE AND HOUR OF DEATH November 9 / 1968 4 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2870 Pelham Avenue		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/1898	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE-housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME HARRY HAUF		14. MOTHER'S MAIDEN NAME Julia DAUGHERTY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-6123		17. INFORMANT 2870 Pelham Ave. ADDRESS JOHN LEIMKUHLER son	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory arrest (B) Cerebro-vascular accident (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 pm. 24 H.		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 9 1968 to November 9 1968 , that (I) (we) last saw the deceased alive on November 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Ellenbogen MD		23B. DATE SIGNED 11/9/1968			
23C. PHYSICIAN'S NAME (Type) ENRIQUE ELLENBOGEN MD		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
25D. ADDRESS 3331 Brehms Lane					

JOHN LEINWALDER

Public - reporting card

Vehicle - records - accident

Xc

of Kentucky

November 2

83

November 2

George C. Cline

George C. Cline

George C. Cline

FUNERAL DIRECTOR: IMPORTANT

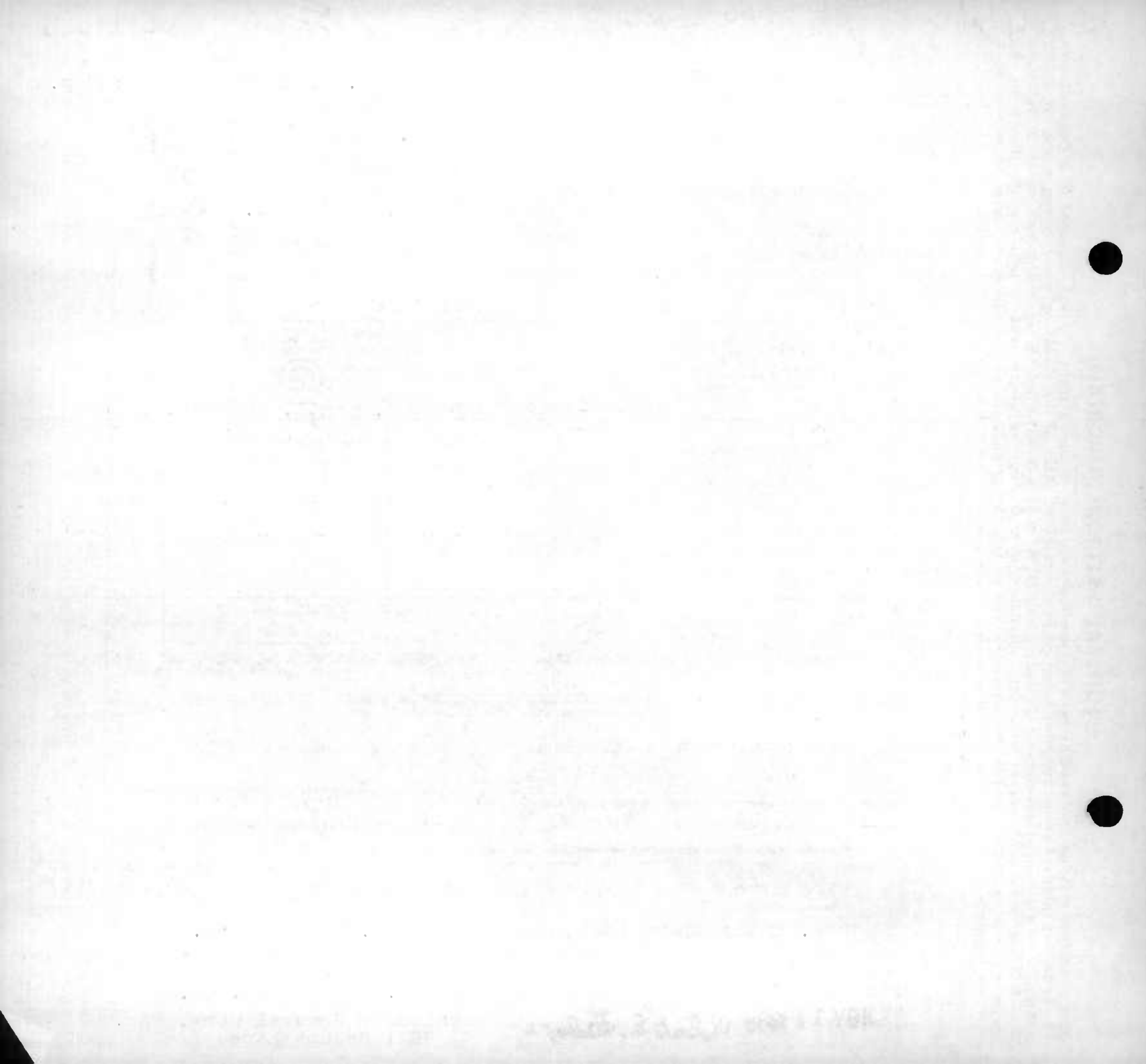
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11326

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIAN KRALL		2. DATE AND HOUR OF DEATH Nov. 8, 1968 5:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md., 21205 B. COUNTY 7-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 611 N. Curley St.		
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/29/04	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Emil Lunak		
14. MOTHER'S MAIDEN NAME unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 212-09-4839		17. INFORMANT Albert A. Krall, husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.0 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute coronary occlusion cardiac infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: old coronary artery disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pericardial sclerosis, hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 24, 1967 to Nov. 8, 1968 , that (I) (we) last saw the deceased alive on Nov. 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.C. Dobihal		23B. DATE SIGNED Nov. 11, 1968		23C. PHYSICIAN'S NAME (Type) Dr. Louis C. Dobihal	
23D. ADDRESS 447 N. Kenwood Ave.		23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
23F. ADDRESS 3331 Brehms Lane		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/12/68		24C. NAME of CEMETERY or CREMATORY Bohemian National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
25D. ADDRESS 3331 Brehms Lane		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11328	
68-11328				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mr. Herman Nieberding		2. DATE AND HOUR OF DEATH 11/10/68 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 21224		
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hosp Baltimore Maryland			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2114 N. Belvidere Ave 24		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-93	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Layout Man		10B. KIND OF BUSINESS OR INDUSTRY Amer. Smelting		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Frank Nieberding		14. MOTHER'S MAIDEN NAME Rennebohn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-2072		17. INFORMANT Madeline Deegan ADDRESS 6413 Danville Ave 21222	
18. CAUSE OF DEATH 203X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple myeloma Pneumonia Congestive Heart failure (B) DUE TO, OR AS A CONSEQUENCE OF: Peripheral Circulatory failure (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 203X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/10/68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10/4/68 to 11/10/68 , that (I) (we) last saw the deceased alive on 11/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Mesbah Uddin MD.	
23B. DATE SIGNED 11.10.68		23C. PHYSICIAN'S NAME (Type) MESBAH UD - DOWLA, MD		23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane			

Chambers & Hays
Baltimore Maryland

M
W

1-1000
1-1000

1000-1000

3111 Belmont Ave

1-21-43

Maryland

Maryland

1000-1000

Multiple myeloma
Gonorrhea
Gonorrhea
Gonorrhea

1000-1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11329

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANKLIN C. ANKORN, Jr

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

November 10, 1968

9:50 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 10, 1968

9:50 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

53-00

6. SEX

male

7. RACE

white

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Feb. 28, 1927

10. AGE (In years
last birthday)

41

Under 1 Yr. If Under 24 Hrs.
Months; Days; Hours; Min.

E. STREET AND NUMBER

6845 Dunbar Road

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF

WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Franklin C. Ankorn

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Policeman-Sgt.

14B. KIND OF BUSINESS OR INDUSTRY

Police Dept.

15. MOTHER'S MAIDEN NAME

Willie Pearl

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korea

17. SOCIAL
SECURITY NO.

235-32-4340

18. INFORMANT

ADDRESS

Mrs. Elsie Ankorn, 6845 Dunbar Road.

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/11/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/15/68

24C. NAME OF CEMETERY or CREMATORY

Odd Fellows Cemetery

24D. LOCATION (City, town, or county)

Parkersburg, W. Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

Robert E. Indigra

25C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS

WALL CITY

WALL CITY

WALL CITY

WALL CITY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11330		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 68-11330	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Edwin G. ABEL, SR			2. DATE AND HOUR OF DEATH 11/6/68 1:10 pm M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital BALTIMORE MD 21205			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3123 VULCAN RD		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-25-05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN ABEL			14. MOTHER'S MAIDEN NAME MARY BINFORD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-03-7648	17. INFORMANT ADDRESS MRS JOSEPHINE ABEL-3123 VULCAN RD		
18. 093.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Antic Arch Aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Syphilis (positive VDRL)			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 months		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 022X II					
19A. DATE OF OPERATION 11/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Antic Arch Aneurysm		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/31/68 19 to 11/6/68 19, that (I) (we) lost saw the deceased alive on 11/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard C Snider, Jr M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 11/6/68	
23C. PHYSICIAN'S NAME (Type) HOWARD C SNIDER, JR			23D. ADDRESS Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/9/68		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
24D. LOCATION COLGATE MD		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS VULCAN FUNERAL HOME-4210 BELAIR RD			

1-10-94

11/6/94

Edwards: 1882

Johns Hopkins Hospital

W. J. ...

...

...

...

Robert ...

8 ... (positive ...)

no

Robert ...

11/6/94

11/6/94

11/6/94

11/6/94

Howard G. ...

Howard G. ...

11/6/94

Johns Hopkins Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11331 CERTIFICATE OF DEATH

REG. NO. 68-11331

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Clara W. Baum		2. DATE AND HOUR OF DEATH Nov. 10, 1968 7:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION Ardleigh Nursing Home 90 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 11-15-68			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2422 A Wellbridge Drive		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 Oct. 25, 1876	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Byrne			14. MOTHER'S MAIDEN NAME Mary - 2 Florence Brooks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Frederick S. Baum, Jr. 2422 A Wellbridge Drive	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-vascular disease 15 yrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 11, 1967 to Nov. 10, 1968, that (I) (we) last saw the deceased alive on November 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D. 23C. PHYSICIAN'S NAME (Type)				23B. DATE SIGNED Nov. 12, 1968 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/68		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Parkville, Md.		24E. ADDRESS 3902 Greenmount Ave.			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.	

Ins. Policy issued in 1887 and son's
affidavit 11-15-68 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11332 CERTIFICATE OF DEATH

REG. NO.

68-11332

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles F Westermeyer

2. DATE AND HOUR OF DEATH

Nov 8/68

1 3 pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

53-00

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2637 Liberty Parkway

5. SEX

male

6. RACE

white

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

May 15 1896

9. AGE (In years
last birthday)

72

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

welder

10B. KIND OF BUSINESS OR INDUSTRY

Esso Refinery

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Rudolph Westermeyer

14. MOTHER'S MAIDEN NAME

Susan Benner

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W I

16. SOCIAL
SECURITY NO.

214 01 4180

17. INFORMANT

ADDRESS

Mrs Lillian Westermeyer 2637 Libert Parkway

18.

250.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Myocardial infarction due to
Arteriosclerotic Heart Disease.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(c) Diabetic. Hypertension, mild.

MEDICAL CERTIFICATION

260X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19
that (I) (we) last saw the deceased alive on November 6 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph D'Antonio M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

Nov. 11, 1968

23C. PHYSICIAN'S
NAME (Type)

Joseph D'Antonio 100M Broadway

DEGREE

23D. ADDRESS

100 N Broadway

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov 11/68

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

Colgate Balto Co

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

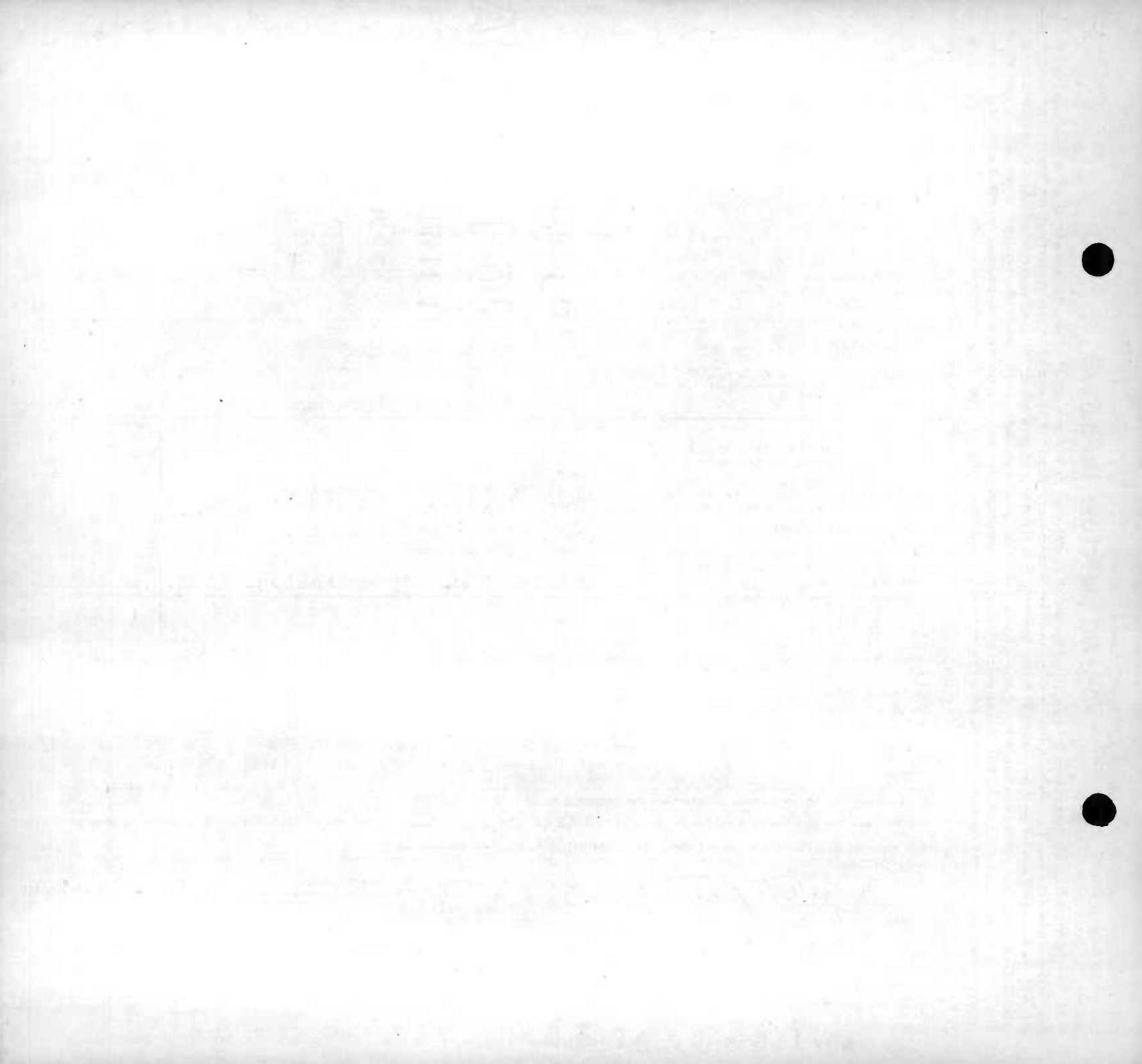
25C. FUNERAL DIRECTOR

ADDRESS

NOV 13 1968

Robert E. Fisher

Ulrich Funeral Home Dundalk Md



FUNERAL DIRECTOR: IMPORTANT

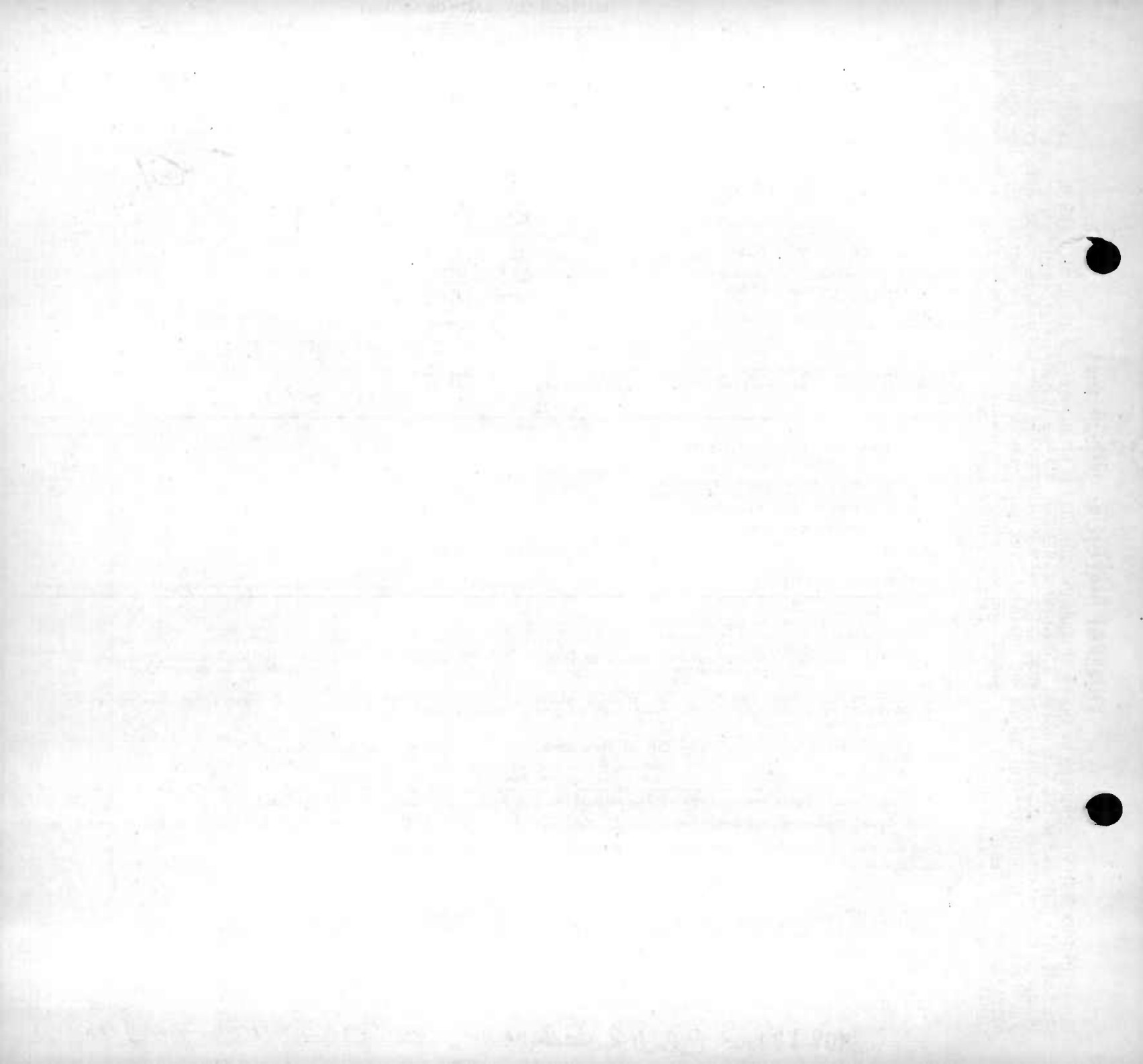
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11333 CERTIFICATE OF DEATH

REG. NO.

68-11333

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BROECKMAN ANNA		2. DATE AND HOUR OF DEATH November 8 '1968 6:20 am.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.		
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSP			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER PARKLAWN AVE 3414		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1906	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DAVID S CARSON			14. MOTHER'S MAIDEN NAME JANE R DEEVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 212-26-8675	17. INFORMANT ADDRESS CORA C GLADSTONE SAME		
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH GA. OF COLON C METASTASIS.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 96 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). NONE					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 8/14/68 to 11/8/68, that (I) (we) last saw the deceased alive on 11-8-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Varnasin			23B. DATE SIGNED 11-8-68		23C. PHYSICIAN'S NAME (Type) C. VARNASIN
23D. ADDRESS FRANKLIN SQUARE			23E. MED. DIRECTOR —		
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT CEMETERY	
24D. LOCATION BALTIMORE MD		24E. NAME OF REGISTRAR —		24F. FUNERAL DIRECTOR —	
24G. DATE REC'D BY HEALTH DEPT. —		24H. NAME OF REGISTRAR —		24I. FUNERAL DIRECTOR —	
24J. DATE REC'D BY HEALTH DEPT. —		24K. NAME OF REGISTRAR —		24L. FUNERAL DIRECTOR —	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11334 CERTIFICATE OF DEATH

REG. NO. 68-11334

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Howard N. Stauffer</u>		2. DATE AND HOUR OF DEATH <u>November 7th 1968 6:40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>Baltimore</u>		B. COUNTY <u>1 Maryland</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5924 Bertram Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/17/1906</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chamfferr</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chamfferr</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Stauffer</u>		14. MOTHER'S MAIDEN NAME <u>Nora Bell Mc Dade</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-013888</u>		17. INFORMANT ADDRESS <u>Doris Mae Stauffer - 5924 Bertram Ave. - 21214</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CELEBRAL SPINA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>One to carcinoma of sigmoid, metastasis to involving brain and lung</u>		CAUSE OF DEATH <u>CELEBRAL SPINA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>One to carcinoma of sigmoid, metastasis to involving brain and lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several Months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>15-3-3 II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>1</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>1</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>October 16th 1968</u> to <u>November 7th 1968</u> , that (I) (we) last saw the deceased alive on <u>November 7th 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael G. Kr</u>		23B. DATE SIGNED <u>11/7/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael G. Kr</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-11-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>John C. Miller Inc-6415</u>		25D. ADDRESS <u>Belair Rd. - 31206</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11335

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Barry</i> JOSEPH MULFORD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968 Hour 4:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5909 Plumer Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968 Hour 4:20 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 1, 1929		10. AGE (In years last birthday) 39 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Salesman		14B. KIND OF BUSINESS OR INDUSTRY A.S. Abell	
15. MOTHER'S MAIDEN NAME Katherine Barry		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 220-22-1073		18. INFORMANT Frieda A. Mulford - 5909 Plumer Ave.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 8, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-11-68	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS	

11

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11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-11336			
1. NAME OF DECEASED (Type or Print) JOSEPH C. ROSCH				2. DATE AND HOUR OF DEATH 11/9/68 12²⁰ P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 ADOLPHUS STS		A. STATE MD.		B. COUNTY VISA		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3567 GARDENWAY Juneway				5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/89	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Boss		10B. KIND OF BUSINESS OR INDUSTRY Home Laundry		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Jacob Roaseh Rosch				14. MOTHER'S MAIDEN NAME Margaret Jordan							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-05-1406 A		17. INFORMANT Hannah R. Rosch - 3567 Juneway - 21213				ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction				CAUSE OF DEATH Acute occlusion of coronary artery.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 420.1 II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular aneurysm.							
				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Y.S.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11/9 1968 to 11/9 1968 , that (I) (we) last saw the deceased alive on 11/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ronald M. Legum M.D.				23B. DATE SIGNED 11/9/68							
23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM, M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11-12-68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) BALTO MD.			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968				25B. NAME OF REGISTRAR Robert E. Johnson				25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. -21206			
								ADDRESS			

1-1-1

1-1-1

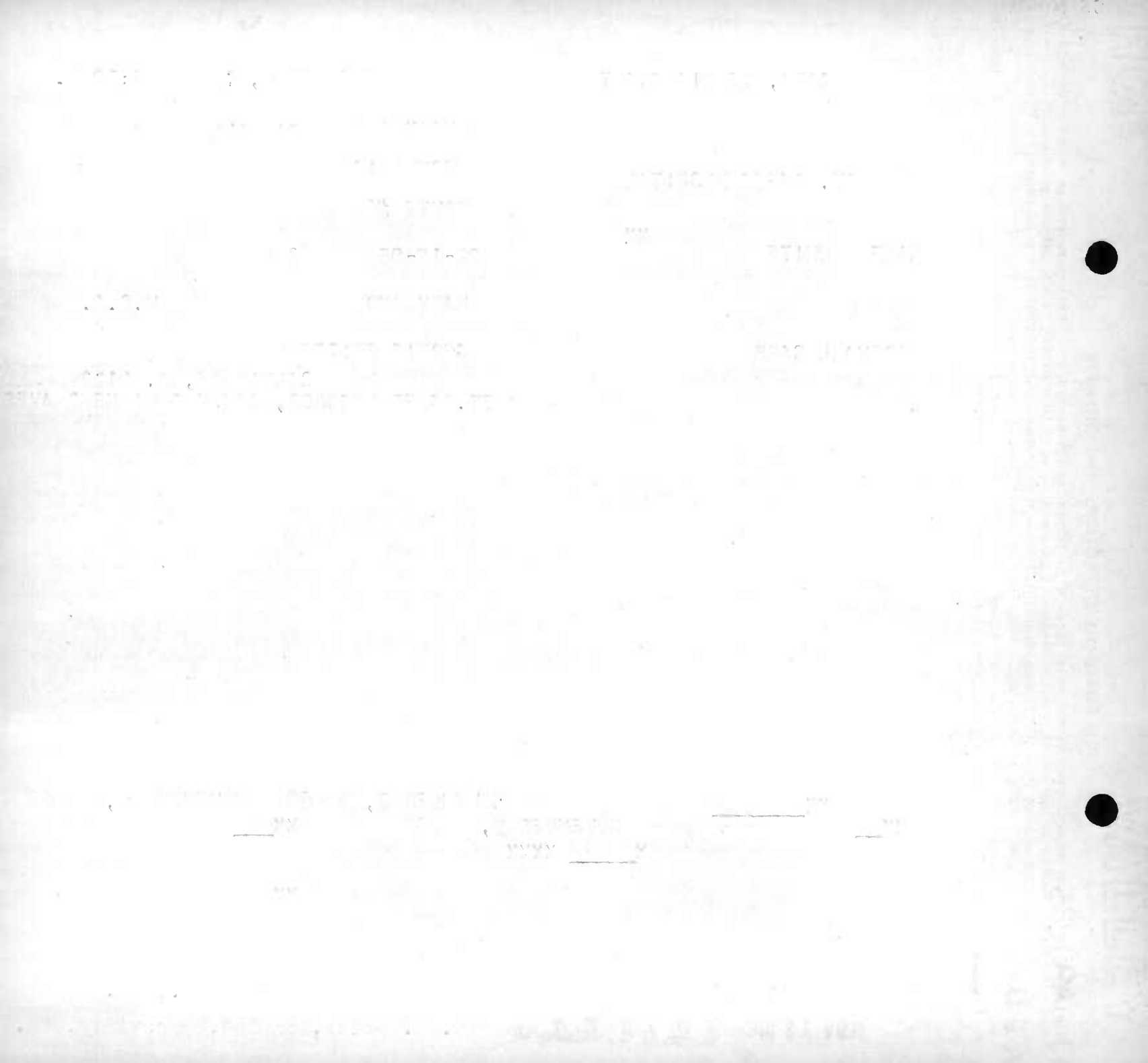
1-1-1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11337 CERTIFICATE OF DEATHREG. NO. 10

68-11337

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARR, DENNIS GRANT		NOVEMBER 9, 1968 5:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		56-00	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		MARYLAND CARROLL		C. CITY OR TOWN WESTMINISTER	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER ROUTE #6			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-10-05	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARSHALL CARR		14. MOTHER'S MAIDEN NAME GERTIE FRIZZELL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-9297		17. INFORMANT BALTIMORE, MD. 21229 ST. AGNES RECORDS, CATON & WILKENS AVES	
18. <u>492X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart failure (Rt Sided)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Emphysema -</u> (C) <u>Bronchial Asthma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>20 years</u>	
19A. DATE OF OPERATION <u>241X</u> II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>NOVEMBER 7, 1968</u> to <u>NOVEMBER 9, 1968</u> , that <u>XIX</u> (we) last saw the deceased alive on <u>NOVEMBER 9, 1968</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alexandro Mejia</u> MD DEGREE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>ALEXANDRO MEJIA MD</u> DEGREE	
23D. ADDRESS <u>St Agnes Hospital - Wilkens + Caton Avenues</u>		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/1968	
24C. NAME OF CEMETERY or CREMATORY Salem Cemetery		24D. LOCATION (City, town, or county) Carroll Co., Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 13 1968	
24F. NAME OF REGISTRAR <u>Robert E. Johnson</u>		24G. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.		24H. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

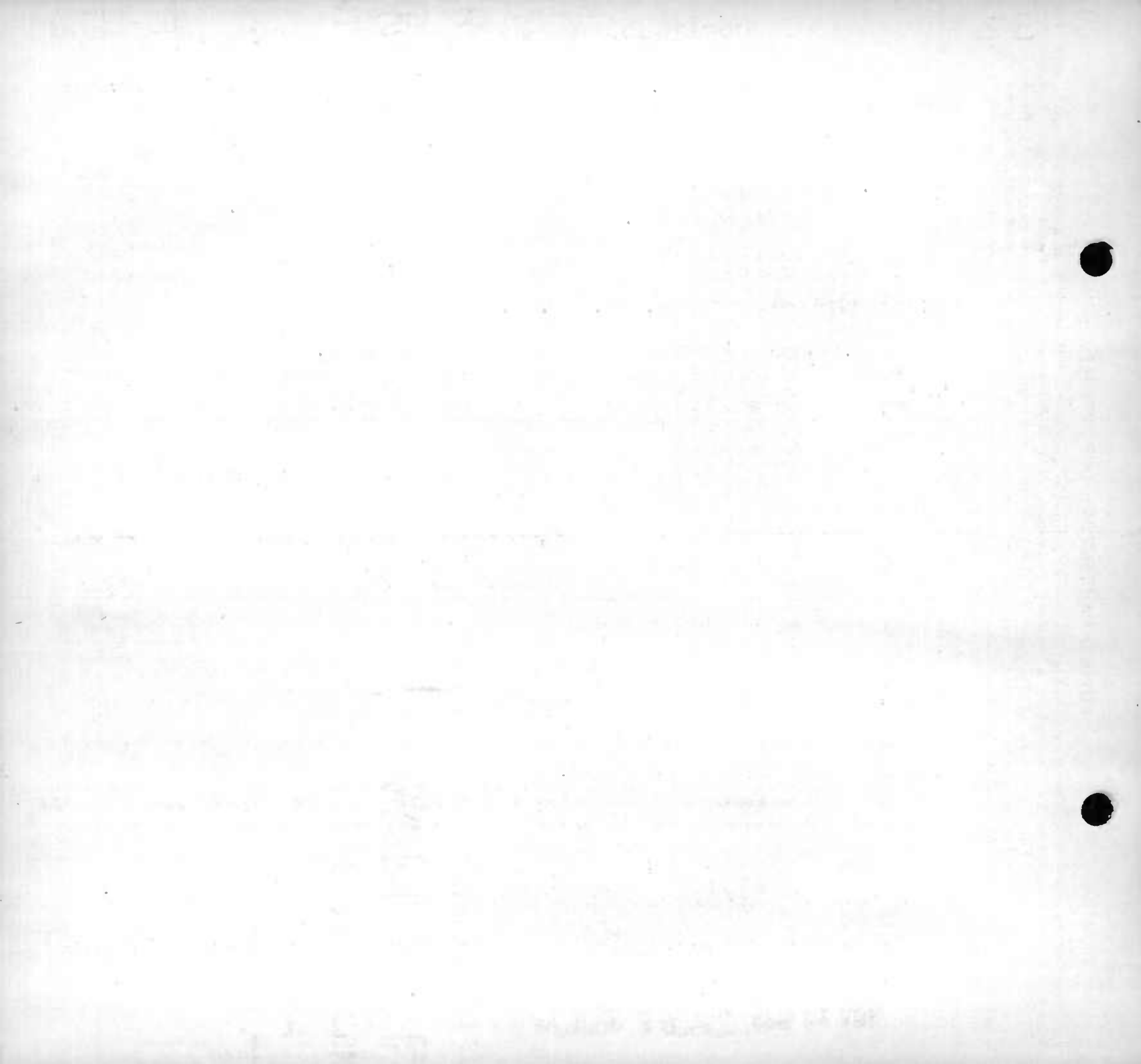
68-11338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11338

1. NAME OF DECEASED (Type or Print) WILLARD R. SPENCE		2. DATE AND HOUR OF DEATH NOVEMBER 10, 1968 12:15PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Caton & Wilkens Aves.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1204 Edmondson Ave.	
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 16, 1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dockmaster		10B. KIND OF BUSINESS OR INDUSTRY Beth. St. Sp. Yd.	11. BIRTHPLACE (State or foreign country) Ohio
13. FATHER'S NAME E. Vernon Spence		14. MOTHER'S MAIDEN NAME Carrie B. Shaw	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. yes	17. INFORMANT ADDRESS Mrs Betty J. Durkos 1504 Midvale Av.
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) Myocardial Ischemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Sclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: 10 yrs (C) 10 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-17- 19 56 to 11-10- 19 68 , that (I) (we) last saw the deceased alive on 11-9- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Wilmer K. Gallagher M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 11/11/68
23C. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.		23D. ADDRESS 6289 Frederick Ave., Baltimore, Md. 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Nov 12, 1968	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemt.	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR ADDRESS Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

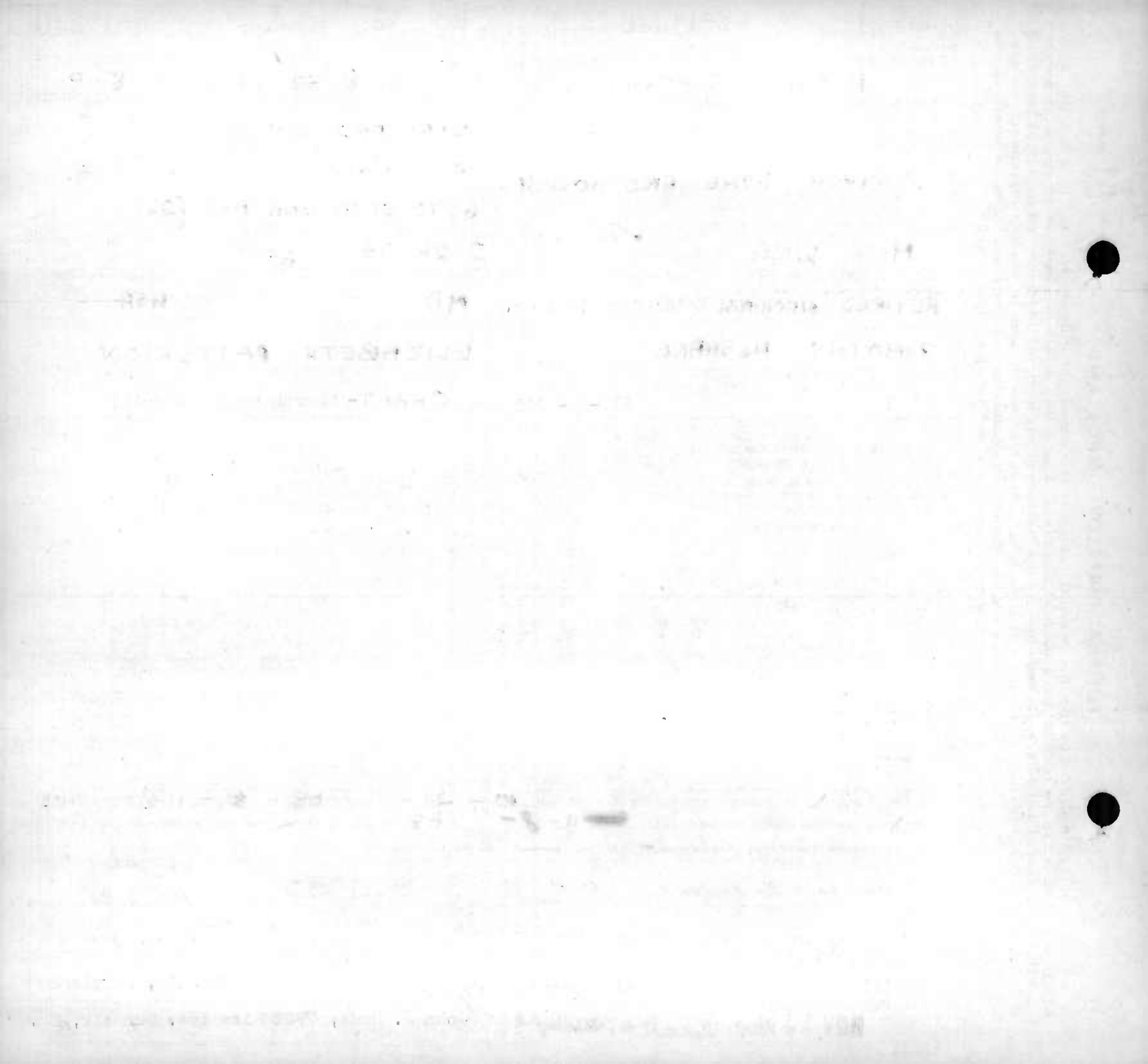
BIRTH NO. 5-530				68-11339		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11339	
M.E. CASE NO. <u>Delaware</u>				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
33 THE JOHNS HOPKINS HOSPITAL				DELAWARE		V-07		DAGSBORO	
15. SEX				16. RACE		17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		18. DATE OF BIRTH	
FEMALE				NEGRO		NEVER MARRIED		9-9-68	
19A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				19B. KIND OF BUSINESS OR INDUSTRY		20. BIRTHPLACE (State or foreign country)		21. CITIZEN OF WHAT COUNTRY?	
None				None		Delaware		USA	
22. FATHER'S NAME				23. MOTHER'S MAIDEN NAME		24. ADDRESS			
WILKINS HATTON				GLORIA SNEAD		Wilkins Hatton Millsboro, Del.			
25. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				26. SOCIAL SECURITY NO.		27. INFORMANT			
No				None		Wilkins Hatton Millsboro, Del.			
28. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				29. CAUSE OF DEATH				30. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) Cardiac arrest					
31. ANTECEDENT CAUSES				(B) anoxia					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Congenital Heart disease - probable Tricuspid atresia				6 wks	
32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				33. none					
34. DATE OF OPERATION				35. CONDITION FOR WHICH OPERATION WAS PERFORMED				36. AUTOPSY (Yes or No)	
none								No	
37. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				38. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				39. WHERE OF INJURY OCCUR?	
No								(If in Baltimore City, give exact location)	
40. TIME OF INJURY (APPROX.)				41. INJURY OCCURRED				42. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
43. I certify that (I) (this hospital) attended the deceased from Oct. 25 1968 to Oct. 26 1968, that (I) (we) last saw the deceased alive on Oct. 26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
44. SIGNATURE				45. DATE SIGNED				46. ADDRESS	
Robert N. Sheff				10-26-68				THE JOHNS HOPKINS HOSPITAL	
47. PHYSICIAN'S NAME (Type)				48. ADDRESS				49. ADDRESS	
ROBERT N. SHEFF				THE JOHNS HOPKINS HOSPITAL				Millsboro, Sussex, Delaware	
50. BURIAL CREMATION, REMOVAL (Specify)				51. DATE				52. NAME OF CEMETERY or CREMATORY	
Burial				Oct. 28, 1968				Old Field Cemetery	
53. DATE RECEIVED				54. NAME OF REGISTRAR				55. FUNERAL DIRECTOR	
NOV 13 1968				Robert E. Fiedler				Millsboro, Del.	

on

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
1. NAME OF DECEASED (Type or Print) Mc SHANE TIMOTHY		TIMOTHY Mc Shane		2. DATE AND HOUR OF DEATH 11-8-1968 8 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6570 ST HELENA AVE (22)		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-03	9. AGE (In years lost birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME TIMOTHY Mc SHANE		
14. MOTHER'S MAIDEN NAME ELIZABETH PATTERSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-01-2505		17. INFORMANT ADDRESS CHART- Church Home & Hospital		
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Bilateral massive Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 465X II Hydrophorax Asites		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that N (this hospital) attended the deceased from 10-21-1968 to 8-11-8-1968 , that N (we) lost saw the deceased alive on 11-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death.				
23A. SIGNATURE Corazon Z. Vergara M.D.		23B. DATE SIGNED 11-9-68		23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.
23D. ADDRESS Church Home & Hospital 160 N. Broadway Baltimore Md 21231		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11/12/68		24C. NAME of CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined eggs; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11341	
BIRTH NO.		68-11341		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Fannie M. Cornick			2. DATE AND HOUR OF DEATH 11/11/68 8:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital Baltimore, Maryland 21205			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2733 The Alameda 21218		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05/28/39	9. AGE (In years last birthday) 29	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jonnie Williams		14. MOTHER'S MAIDEN NAME Marie Scott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Joseph Cornick, Jr. 2733 The Alameda	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Liver Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Post-neurotic cirrhosis Chronic active hepatitis Diabetes Mellitus OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 3-8-10 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 yrs. 4 yrs.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 47 (this hospital) attended the deceased from Aug. 30 19 68 to Nov. 11 19 68 , that (I) (we) last saw the deceased alive on 11/11/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 47 (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joel Engelstein			23B. DATE SIGNED 11/11/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Joel M. Engelstein, M.D.			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-15-68		24C. NAME OF CEMETERY or CREMATORY Balto. National cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. 1735 Harford			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11342

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN CHADWICK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 10, 1968		Hour 12:15 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 10, 1968		Hour 12:15 A.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept 6, 1951		10. AGE (In years lost birthday) 17	11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Archie Chadwick		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter
15. MOTHER'S MAIDEN NAME Alice Hazel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217-54-1041
18. INFORMANT Alice Chadwick		ADDRESS 1413 N. Fremont		19. CAUSE OF DEATH E 9651 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 1801 Little Wash Street
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 9, 1968 8:45 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot while standing on pavement
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 10, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/14/68	24C. NAME of CEMETERY or CREMATORY Mt Auburn Cem.	24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968	25B. NAME OF REGISTRAR Robert E. Fiedora	25C. FUNERAL DIRECTOR Earl Gilmore ADDRESS 1827 W. North Ave		

Sept, 1951

Post No.

7-10

no

British Columbia

Department of Fisheries

200-1000000000-1000000000

WILLIF

Revenue, 11/4/51 Not known from Post. No.

not known from Post. No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11343

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARRY S. PUMPHREY

2. DATE AND HOUR OF DEATH

11-9-68

5:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL HOSP.
3001 S. HANNOVER ST. BALTO, MD.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD Ann Arundel

52-00

C. CITY OR TOWN

Millersville

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

Box 182 Rt 2

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-24-20

9. AGE (In years last birthday)

48

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OWNER - TAVERN

10B. KIND OF BUSINESS OR INDUSTRY

TAVERN

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN PUMPHREY

14. MOTHER'S MAIDEN NAME

ANNA MAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes?

WW II

16. SOCIAL SECURITY NO.

160-149387

17. INFORMANT

from chart

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Heart Failure - Pulmonary Edema

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

(C)

Diabetes Mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

260X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cirrhosis - liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-2 19 68 to 5:20 AM 11-9 19 68, that (I) (we) last saw the deceased alive on 5:20 AM 11-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. G. Baumann M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-9-68

23C. PHYSICIAN'S NAME (Type)

C. G. BAUMANN M.D.

23D. ADDRESS

3001 S. Hanover St. BALTIMORE MD 21230

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

11/12/68

Glenn Haven Memorial PK.

Blon Burnie

MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 13 1968

Robert E. Jackson

Edgington Funeral Home / Blon Burnie, MD

48

100-1000

100-1000

100-1000

100-1000 100-1000 100-1000 100-1000 100-1000 100-1000 100-1000 100-1000 100-1000 100-1000

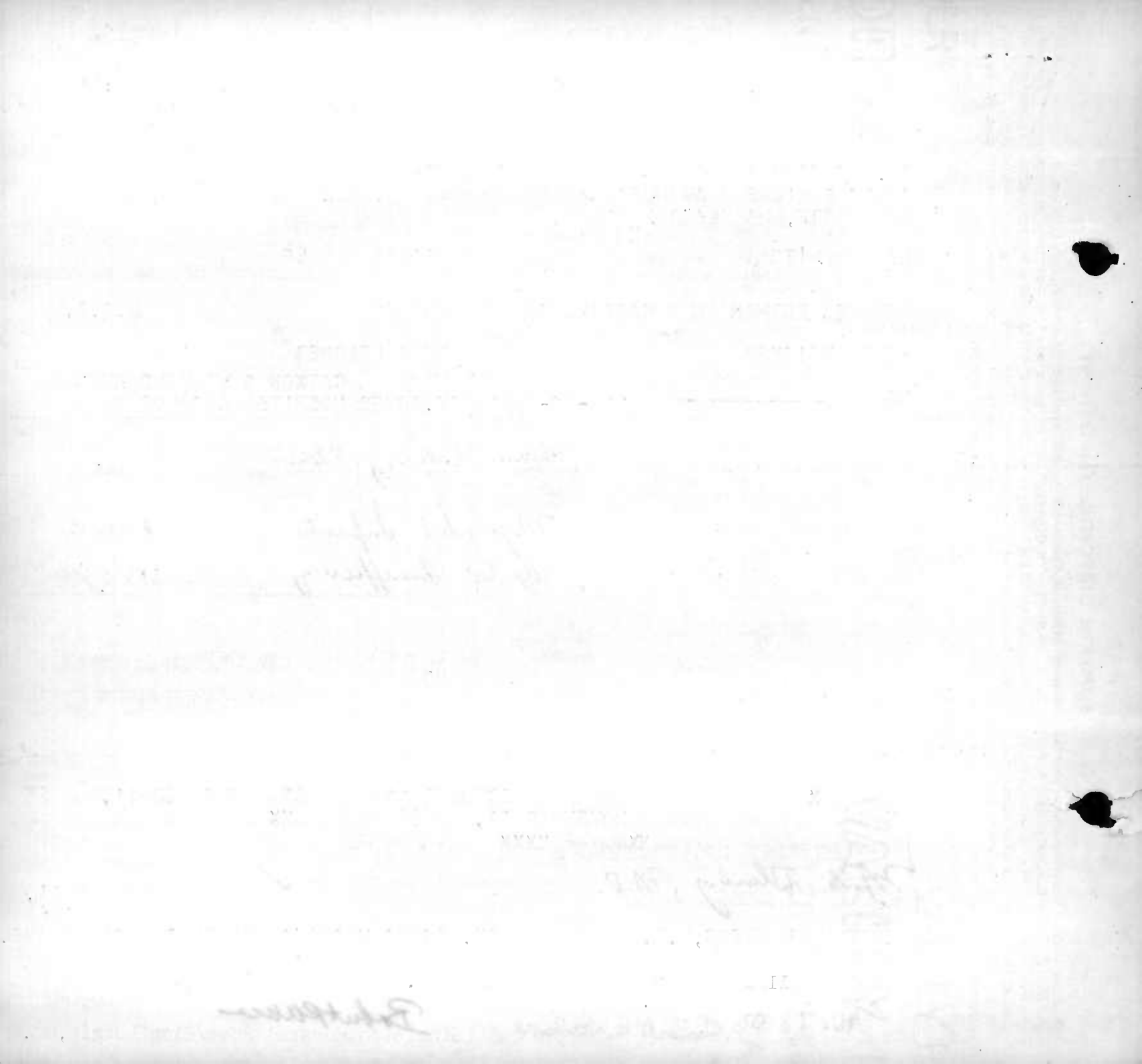
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11344 CERTIFICATE OF DEATH

REG. NO. 68-11344

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MEISTER, GEORGE FREDERICK		2. DATE AND HOUR OF DEATH NOVEMBER 11, 1968 2:25 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21227 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2811 MANOFF ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/13/88	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSE FORMAN			10B. KIND OF BUSINESS OR INDUSTRY W B CASSELL CO		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HENRY MEISTER		
14. MOTHER'S MAIDEN NAME LENA LEISNER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 215-05-6992			17. INFORMANT CATON & WILKENS AVENUE ST. AGNES HOSPITAL RECORDS		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Massive Pulmonary Edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Aortic Insufficiency (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 75 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 22 19 68 to NOVEMBER 11 , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on NOVEMBER 11 , 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morton Blumberg, M.D.				23B. DATE SIGNED NOVEMBER 11, 1968	
23C. PHYSICIAN'S NAME (Type) MORTON BLUMBERG, M.D.				23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk.	
24D. LOCATION Glen Burnie Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25A. NAME OF REGISTRAR Robert E. Jackson		25B. FUNERAL DIRECTOR Robert E. Jackson		25C. ADDRESS Singleton Funeral Home/Glen Burnie, Md.	



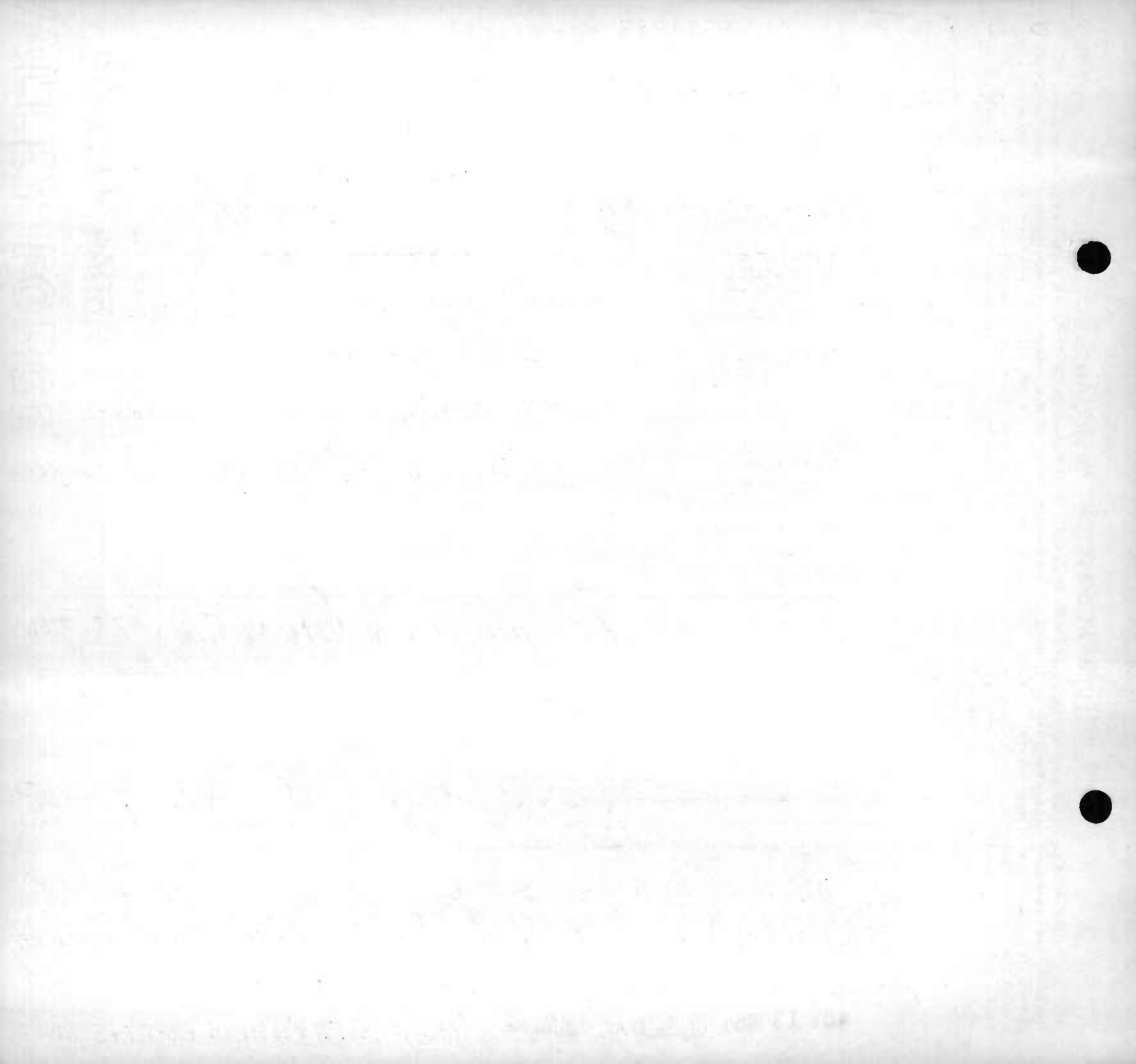
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11345 CERTIFICATE OF DEATH

REG. NO. 68-11345

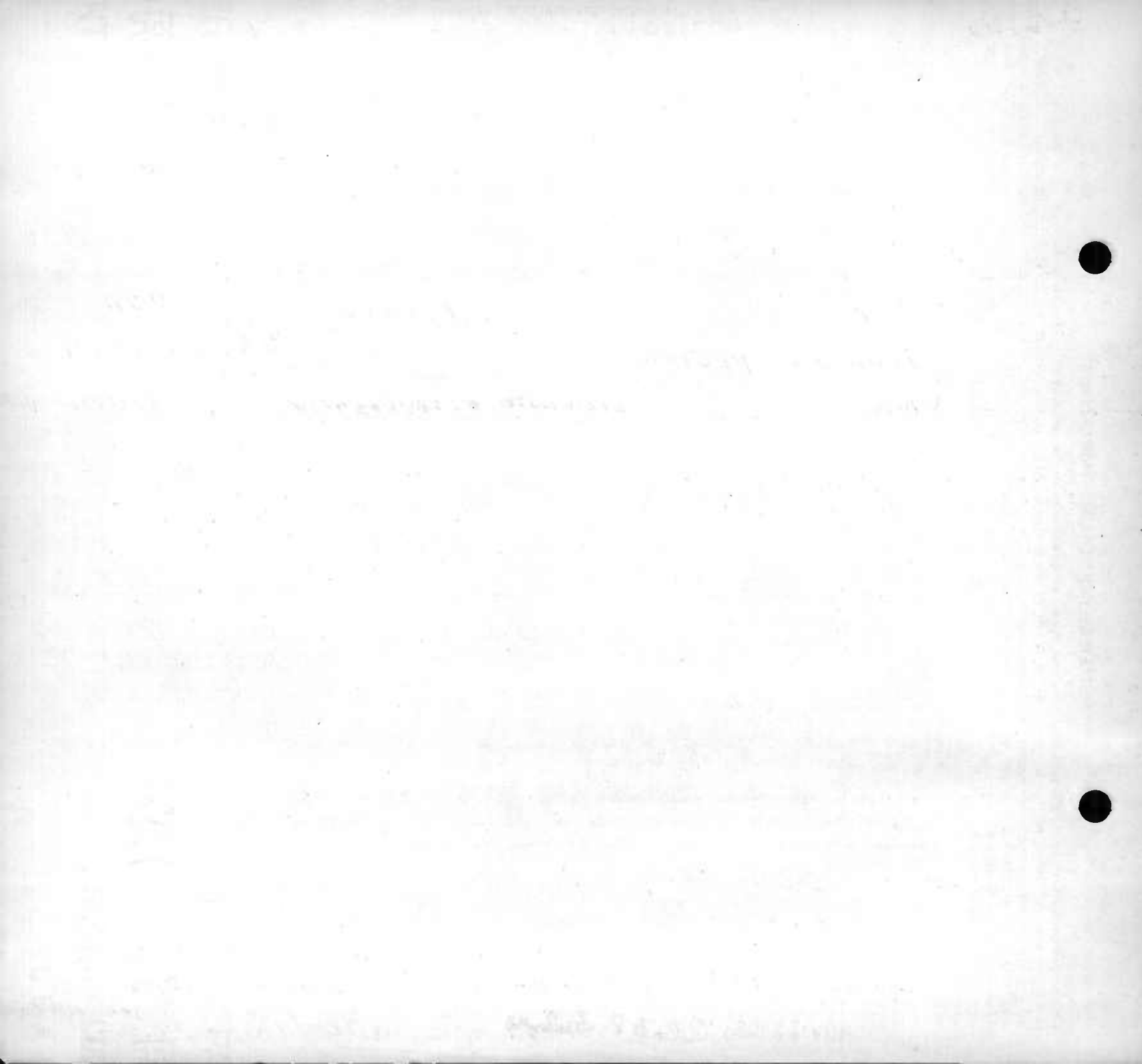
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARROLL L. STEINMETZ		2. DATE AND HOUR OF DEATH NOV. 9 - 1968 2 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1812 RAMSAY ST.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 19-04		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-27-1908		9. AGE (In years last birthday) 60		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY SOAP COMPANY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CARROLL L. STEINMETZ		14. MOTHER'S MAIDEN NAME LYDIA O'NEIL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-05-7569		17. INFORMANT AGNES STEINMETZ ADDRESS 1812 RAMSAY ST.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cause of lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Emphysema, Bronchitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
19. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was hospital) attended the deceased from Nov 8 19 68 to Nov 9 19 68 , that (I) (was) last saw the deceased alive on Nov 8 19 68 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christian S. Mass		23B. DATE SIGNED 11/11/68		23C. PHYSICIAN'S NAME (Type or Print) CHRISTIAN S. MASS	
23D. ADDRESS 21 S. St. John's Lane		23E. CITY BALTIMORE		23F. STATE MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-12-68		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND.		24E. STATE MARYLAND		24F. ZIP CODE 21201	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR WALTERS FUN'L HOME PRATT & STRICKER	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-240				68-11346		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. X		68-11346			
BIRTH NO.						CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>PEGLOW LEE F.</u>						2. DATE AND HOUR OF DEATH <u>11/8/68 at 9.10 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>16 Lutheran Hospital of Maryland</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> <u>53-00</u>							
						C. CITY OR TOWN <u>Baltimore</u> <u>ESSEX</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
						E. STREET AND NUMBER <u>2 A Tanney Smith</u>							
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02-04-02</u>		9. AGE (In years lost birthday) <u>66</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airport - mechanic</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>FRANCES PEGLOW</u>						14. MOTHER'S MAIDEN NAME <u>EROSZYNSKI</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNIK</u>				16. SOCIAL SECURITY NO. <u>212-07-5860</u>		17. INFORMANT <u>M. LAUERSTEIN</u>			ADDRESS <u>EASTMAN AVE</u>				
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>						20. <u>Hypertension, Respiratory & circulatory impairment</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>10-31-1968</u> to <u>11-8-1968</u> , that (I) (we) last saw the deceased alive on <u>11-8-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Ch. Kuckson</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) <u>G. MATHIPRAKASAM M.D.</u>						23D. ADDRESS <u>Lutheran Hospital of Maryland</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Cosmely Funeral Home</u>		ADDRESS <u>300 MACE</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11347 CERTIFICATE OF DEATH

REG. NO. 68-11347

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS. JOSEPHINE STEELE		2. DATE AND HOUR OF DEATH Nov. 10th 1968 7:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY, BALTO. MD. 21231			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 421 VIRGINIA AVENUE 21221		
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 8 1926	9. AGE (In years lost birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME VINCENT ORSINI			14. MOTHER'S MAIDEN NAME D'ANDRAIO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JAMES STEEL ABOVE	
18. 3877.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Hemorrhagic Pancreatitis 4 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 587.0 II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION Nov. 9, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abdomen		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Does not apply		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Does not apply	
21D. TIME OF INJURY (APPROX.) Does not apply		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Does not apply	
22. I certify that (1) (this hospital) attended the deceased from Nov. 8 1968 to Nov. 10th 1968, that (1) (we) last saw the deceased alive on Nov. 10th 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. F. AZAM M.B.B.S. DEGREE				23B. DATE SIGNED Nov. 10th 1968	
23C. PHYSICIAN'S NAME (Type) A. F. AZAM M.B.B.S. DEGREE		23D. ADDRESS Church Home & Hospital Balto. Md 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/13/68		24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR John E. Sedberry		25C. FUNERAL DIRECTOR ADDRESS J.E. CONNELLY SONS 300 MACE			

NOT RECORDED
NOT FOR FILE

Acute Hemorrhagic Pancreatitis

Nov. 1968 Acute Abdomen
No Does not apply
Does not apply
Nov. 1968
Nov. 1968
Nov. 1968

A.F. AZAM M.D. 200A
Clinical History & Hospital
Nov 10 1968

68-11348

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11348

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILTON J. MYERS

2. DATE
OF
DEATHKnown ☐
Estimated ☐Month Day Year
November 8, 1968Hour
5:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION) PIER # 6 - PRATT ST.

00 S.S. OCEANIC ONDINE (DOA) 3-02

3. DATE
PRONOUNCED DEADMonth Day Year
November 8, 1968Hour
5:00 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6/11/13

10. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

625 S. Savage Street

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH MYERS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEVEDORE

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

CLEMIE WARRICK

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

17. SOCIAL
SECURITY NO.

217-037407

18. INFORMANT

ANNA MYERS

ADDRESS

ABOVE

19.

412.4

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 9, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11/12/68

24C. NAME of CEMETERY or CREMATORY

MEADOW RIDGE

24D. LOCATION (City, town, or county)

BALTO. MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

J. G. CONNELLY

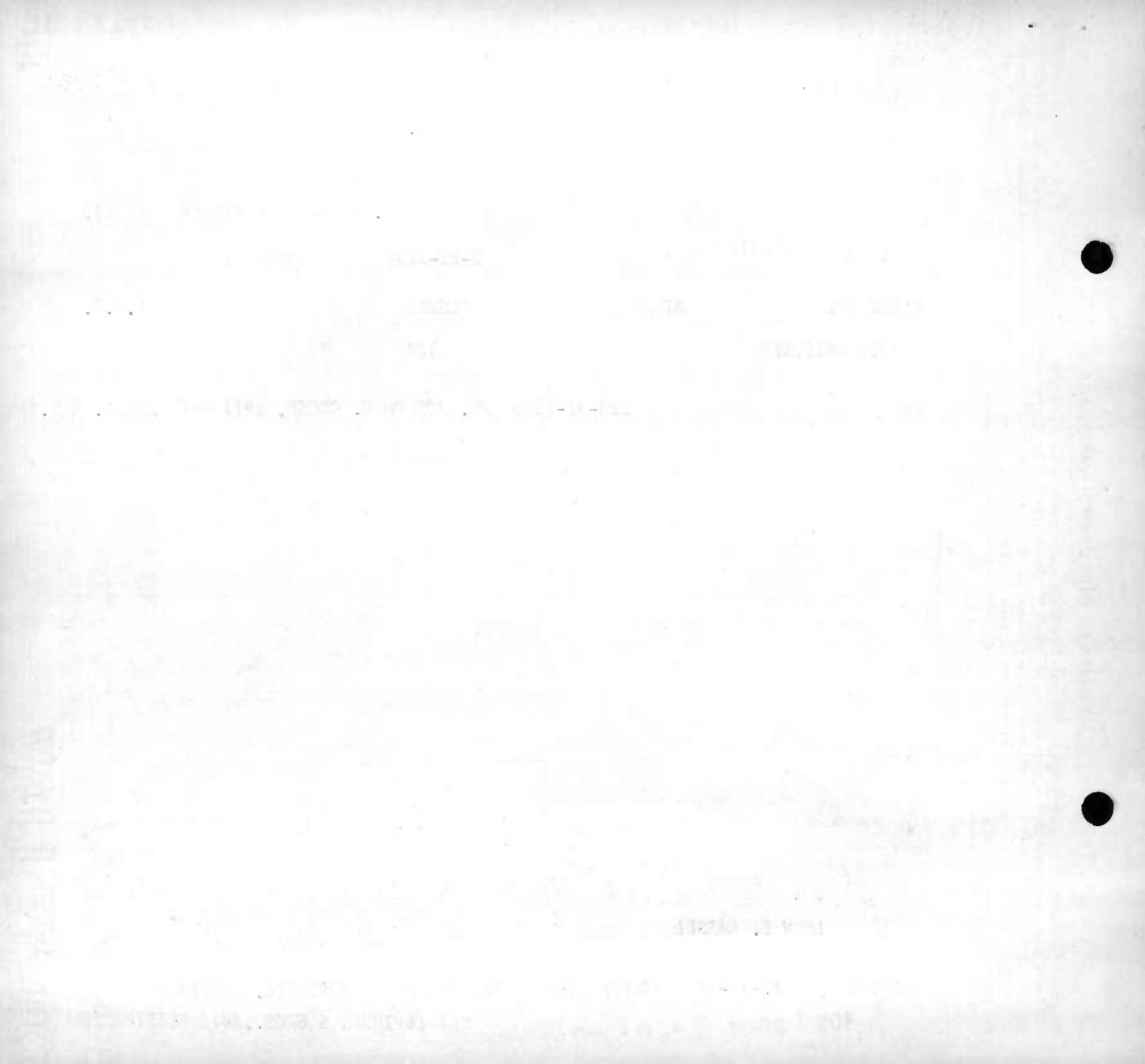
ADDRESS

SONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620 68-11349				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11349	
1. NAME OF DECEASED (Type or Print) <i>Gross, Dora</i>				2. DATE AND HOUR OF DEATH <i>11/9/68 1200</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Linai Hosp of Balto.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY <i>27-20</i>	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4014 W. STRATHMORE AVENUE #21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1889	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED KOLODNER				14. MOTHER'S MAIDEN NAME IDA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-46-2803		17. INFORMANT DR. JOSEPH B. GROSS, 6911 PARK HEIGHTS, AVE. #15			
18. <i>410.9 + 260.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Arteriosclerotic Cardiovascular disease		20 yrs.	
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Diabetes Mellitus						20 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 1955</i> to <i>11/9 1968</i> , that (I) (we) last saw the deceased alive on <i>11/9 1968</i> and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Leon E. Kassel MD</i>				23B. DATE SIGNED <i>11/9/68</i>		23C. PHYSICIAN'S NAME (Type) LEON E. KASSEL	
23D. ADDRESS 3501 ST. PAUL ST, Balto, Md.		23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-10-68		24C. NAME of CEMETERY or CREMATORY AGUDAS ACHIM ANSHE SFARD		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR <i>Rebecca Johnson</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1W-523		68-11350		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11350	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) WEINSTEIN, LOUIS				11-8-1968 10:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL				A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER FENWICK APTS., 1700 MERIDENE DR. #21212							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY ROBERT HALL		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC WEINSTEIN				14. MOTHER'S MAIDEN NAME SARAH I. LAZARUS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY		16. SOCIAL SECURITY NO. 218-32-6224		17. INFORMANT ADDRESS FENWICK APTS. MRS. HELEN WEINSTEIN, 1700 MERIDENE DR. #12			
18. 4120131 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) INTESTINAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MESENTERIC THROMBOSIS WITH EMBOLISM ATHEROSCLEROTIC CARDIOVASCULAR DISEASE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CORONARY ARTERY DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 11-8-1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL INFARCTION		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 11-6-1968 to 11-8-1968 , that (H) (we) last saw the deceased alive on 11-8-1968 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Notarangelo M.D.						23B. DATE SIGNED 11-8-1968	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.						23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-12-68		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D. BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

5/17/92 2H 10:23AM

11-2-11 2010-12-11 11-2-11

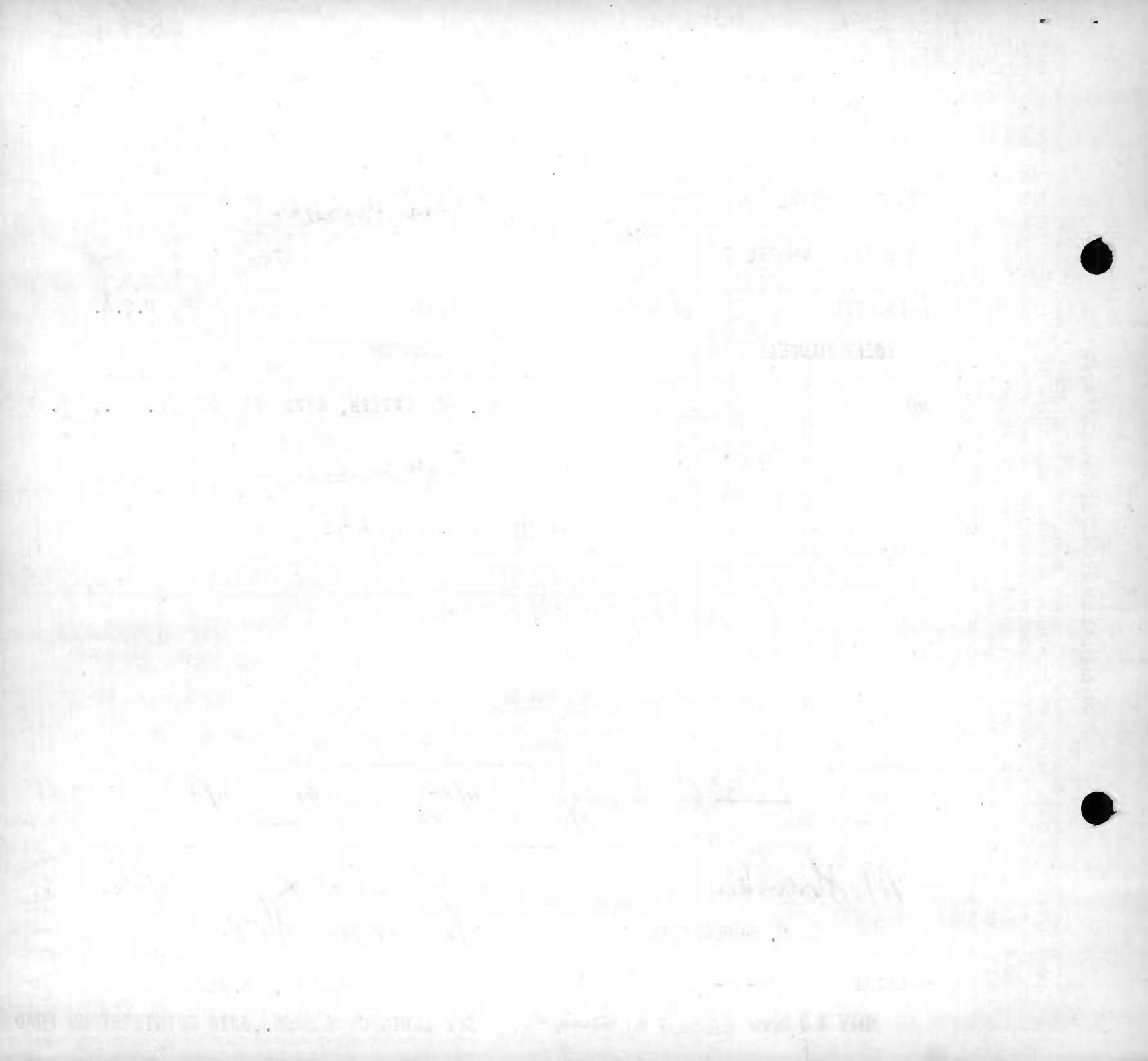
12 - 2-11 32 - 2-11
 13 - 2-11 32 - 2-11

Joseph Notary Public
Joseph Notary Public
11-8-1908
11-8-1908

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11351	
1. NAME OF DECEASED (Type or Print) IDA ETTLIN				2. DATE AND HOUR OF DEATH Nov. 8, 1968 12:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 53-00			
				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6822 Huntington Dr			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOZER MINDEL				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. BEN ETTLIN, 6972 MILBROOK PK. DR., APT. 1 C			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septecemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute cholecystitis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 583 X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/8 19 68 to 11/9 19 68 , that (I) (we) last saw the deceased alive on 11/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Horenstein				23B. DATE SIGNED 11/9/68		23C. PHYSICIAN'S NAME (Type) M. HORENSTEIN	
23D. ADDRESS Sinai Hosp.		23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-10-68		24C. NAME of CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11352	
<div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED (Type or Print) REBECCA PRESS 2. DATE AND HOUR OF DEATH NOV 9 1968 7 30 A.M. </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP OF. BALTO. BALTIMORE, MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-15 C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5805 KEY AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME SOLOMON TAYLOR			14. MOTHER'S MAIDEN NAME MIRA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-7217D		17. INFORMANT ADDRESS MRS. MICHAEL WEINSTEIN, 5805 KEY AVENUE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 40 DAYS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD several years OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Urinary tract infection - pseudomonas a.					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Not App		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Not Applicable	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) NONE		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N.A.	
22. I certify that (1) (this hospital) attended the deceased from OCT 1 1968 to NOV 9 1968 , that (2) (we) last saw the deceased alive on NOV 8 1968 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Stuart H. Spielman MD				23B. DATE SIGNED Nov 9 1968	
23C. PHYSICIAN'S NAME (Type) DR. STUART H. SPIELMAN MD		23D. ADDRESS SINAI HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-10-68		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR Robert E. Indryns		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11353 CERTIFICATE OF DEATH

REG. NO. **68-11353**

BIRTH NO. 52		1. NAME OF DECEASED (Type or Print) SOL KRONBERG		2. DATE AND HOUR OF DEATH 11/9/68 9:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 4824 Pimlico Road					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1903	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Samuel Kronsberg		
14. MOTHER'S MAIDEN NAME Rose Yarmith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-03-6725			17. INFORMANT Mrs. Sophie Kronsberg 4824 Pimlico Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease			DUE TO, OR AS A CONSEQUENCE OF: 6 years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to March 20 19 68 , that (I) (we) last saw the deceased alive on March 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert I. Levy MD				23B. DATE SIGNED 11/9/68	
23C. PHYSICIAN'S NAME (Type) ROBERT I. LEVY				23D. ADDRESS MEDICAL ARTS BLDG.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 10, 1968		24C. NAME OF CEMETERY or CREMATORY Shaarei Zion	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR Robert E. Jacobson		25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road			

MINISTRY OF AGRICULTURE

DEPARTMENT OF AGRICULTURE

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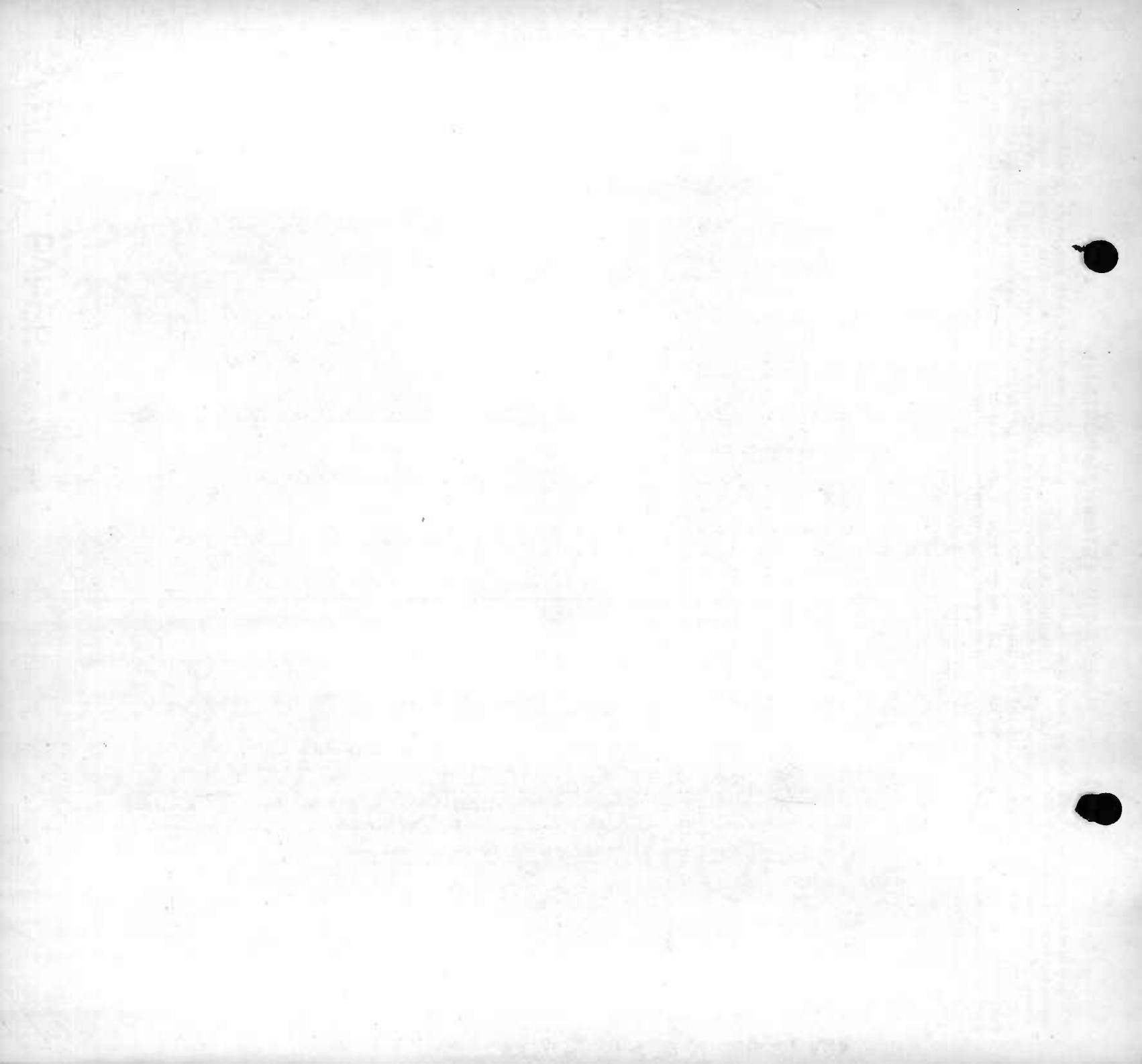
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11354
BIRTH NO.		68-11354		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HAROLD A CAMPBELL			2. DATE AND HOUR OF DEATH 11/12/68 7 50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX MALE			6. RACE NEGRO		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/24/1923		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) W. VA. Piedmont		
10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CHARLES Campbell			14. MOTHER'S MAIDEN NAME FRIEDA Campbell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/2/45 - 12/1/48			16. SOCIAL SECURITY NO. 219-16-9030		
17. INFORMANT Mrs. Blanche Campbell			ADDRESS Same		
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 hour		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: 7 hrs		
			(B) CHRONIC HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: 1 yr.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 430.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11-12-1968		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 11-12-1968	
22. I certify that (I) (this hospital) attended the deceased from 11-11-1968 to 11-12-1968 , that (I) (we) lost saw the deceased alive on 11-12-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley R. Weimer, M.D.				23B. DATE SIGNED 11-12-68	
23C. PHYSICIAN'S NAME (Type) Stanley R. Weimer, M.D.				23D. ADDRESS South Bst. General Hosp.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11-15-68		24C. NAME OF CEMETERY or CREMATORY Balt. Nat'l Cem.	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR Morton S. Dyett, F.H.		24F. ADDRESS 1701 Laurens St	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

NOV 13 1968



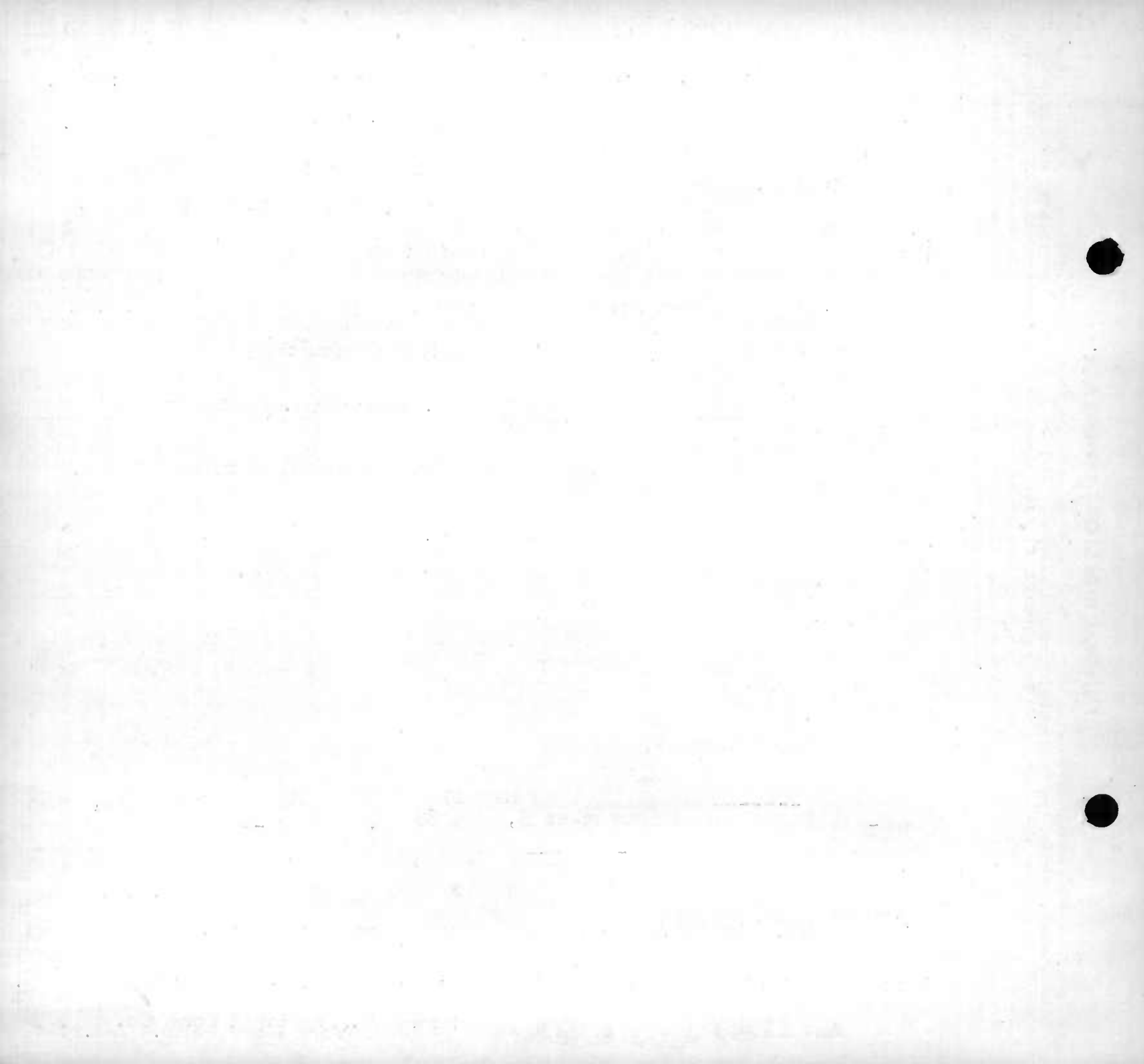
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11355 CERTIFICATE OF DEATH

REG. NO. **68-11355**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Ruth E. Morse		2. DATE AND HOUR OF DEATH 11-11-68 1:30 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1661 E. Cold Spring Lane		C. CITY OR TOWN Baltimore 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1661 E. Cold Spring Lane			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1902	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Woods		14. MOTHER'S MAIDEN NAME Selena Caloquete	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No		16. SOCIAL SECURITY NO. 202-26-3187		17. INFORMANT Mrs. Priscilla I. Adkins 2803 Kingsbridge Road	
18. 158801 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RETROPERITONEAL SARCOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE RETROPERITONEAL SARCOMA DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1588X II					
19A. DATE OF OPERATION 12/13/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of retroperitoneal growth		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 17 1966 to November 11, 1968 , that (I) (we) last saw the deceased alive on November 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov. 12, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor		23D. ADDRESS 3902 Greenmount Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
		24D. LOCATION (City, town, or county) Baltimore County, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR <i>John E. Jenkins</i>		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11356 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11356

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY E. DASCH		2. DATE AND HOUR OF DEATH 11-12-68 9:25 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSP. 100 N. BROADWAY			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 264 S. BOULDER ST.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-91	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A. AMERICAN		13. FATHER'S NAME JOHN H. DINGES			
14. MOTHER'S MAIDEN NAME MARY HARDY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 217018404		17. INFORMANT CHARLES E. DASCH ADDRESS (SAME)			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction w/ chest pain			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary insufficiency; Arteriosclerotic heart disease					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-28 19 68 to 11-12 19 68 , that (I) (we) last saw the deceased alive on 10-12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Mier Sr. M.D. M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 11-12-68	
23C. PHYSICIAN'S NAME (Type) Jose Mier Sr. M.D.				23D. ADDRESS Church Home - Hosp BALT MD 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville, Balto. Co., Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md.	

CHURCH MEMBERS & OFFICERS
100 N. BROADWAY

FRANCIS WHITE

HOUSE WIFE

JOHN H. DINGER

STREET

CHARLES F. BACH

that night
was the night of the 2nd

coming in of the 2nd
last year

10-11

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11357

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas H. Sherrard

2. DATE AND HOUR OF DEATH

November 11, 1968 2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore 21218

YES ☒NO ☐

E. STREET AND NUMBER

4107 Westview Road

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

June 15, 1894

9. AGE (In years
lost birthday)

74

If Under 1 Yr.
MonthsIf Under 24 Hrs.
DaysHours
Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired- VicePresident Acme Markets

10B. KIND OF BUSINESS OR INDUSTRY

Ireland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

David Sherrard

14. MOTHER'S MAIDEN NAME

Maria Houston

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

172-03-5900A

17. INFORMANT

Mrs. Mildred L. Sherrard

ADDRESS

(Same)

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Myocardial infarct

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary artery disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C) Diabetes mellitus

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

30 min.

20 yrs. plus.

20 yrs. plus

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Carcinoma of the colon

4 yrs.

19A. DATE OF OPERATION

Aug. 31, 1966

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Carcinoma of the colon

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1946 to Nov. 11, 1968
that (I) last saw the deceased alive on Nov. 8, 1968 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Robert B. Wright

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

Nov. 11-1968

23C. PHYSICIAN'S
NAME (Type)

Dr. Robert B. Wright

23D. ADDRESS

4121 Westview Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/14/68

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy. A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11358

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HASTINGS, WILLIAM GORDON		2. DATE AND HOUR OF DEATH 11/12/68 6:00 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-48		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1007 CAMERON RD.					
5. SEX m	6. RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/14	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRUGGIST MGR.		10B. KIND OF BUSINESS OR INDUSTRY DRUG CITY		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? md. U.S.A.					
13. FATHER'S NAME LEWIS G. HASTINGS			14. MOTHER'S MAIDEN NAME MARY B. THOMAS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 194-09-5887		17. INFORMANT (WIFE) KATHERINE JEAN HASTINGS (AME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.8 II Capfluent Bunchepneumonia febrile		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: Acute peritonitis with abscess formation (C) yp.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 29/24/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca COLOMB		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/17/68 19 to 11/12 19 68 , that (I) (we) last saw the deceased alive on 11/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown DEGREE				23B. DATE SIGNED 11/12/68	
23C. PHYSICIAN'S NAME (Type) Dr. Charles S. Brown DEGREE				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore,		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Sisk		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

Office Building
Hoboken

State of New Jersey
Hoboken

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 68-11359				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11359	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Pessie Brown				2. DATE AND HOUR OF DEATH 11/9/68 1135 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 427 Oxford Court. D. STREET ADDRESS (If rural, give location) 11-04			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 2-2-91	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hardresser, domestic				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME not known			
14. MOTHER'S MAIDEN NAME not known				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 917-32-7988A				17. INFORMANT Alice Powell ADDRESS niece			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) Cerebrovascular hemorrhage				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Hypertensive Cerebrovascular disease Hypertension-essential, generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 72 hours				19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none			
19A. DATE OF OPERATION 3 10/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aortic aneurysm		20A. AUTOPSY? Yes or No YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 11/9/68		21H. DATE SIGNED 11/9/68	
22. I certify that (I) (this hospital) attended the deceased from 10/29 1968 to 11/9 1968 , that (I) (we) last saw the deceased alive on 11/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Robert S. Kurtz M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23B. PHYSICIAN'S NAME (Type) Robert S. Kurtz M.D.				23C. ADDRESS Johns Hopkins Hospital Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE SIGNED BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Faulkner		25C. FUNERAL DIRECTOR Virgil Ringgold		25D. ADDRESS 146371 Can...	

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FUNERAL DIRECTOR: IMPORTANT

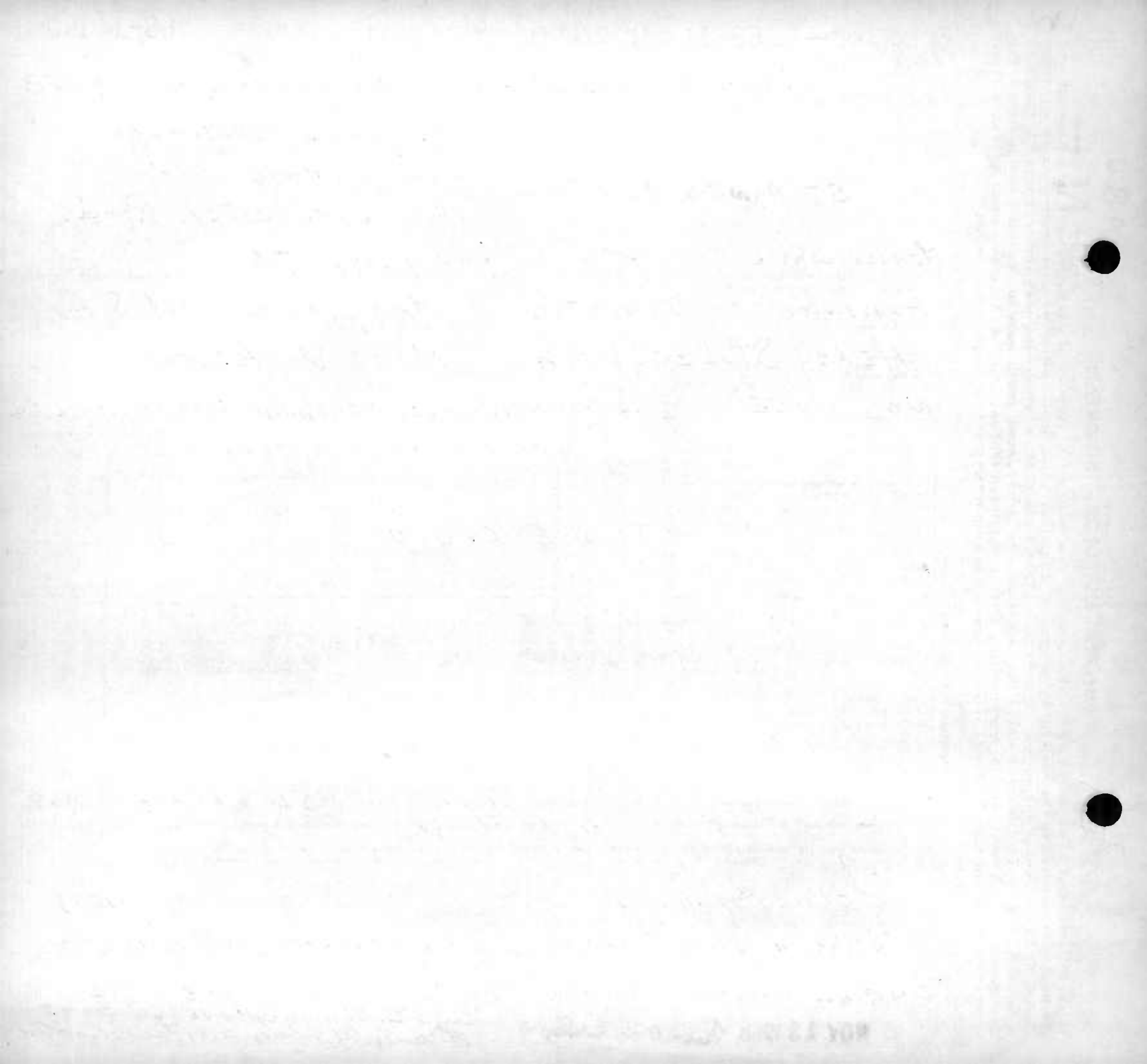
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-11360 CERTIFICATE OF DEATH

REG. NO. 68-11360

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY L. MEYSHAW		NOVEMBER 10 1968 9:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL				A. STATE MARYLAND BALTIMORE 53-00	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN CATONSVILLE MARYLAND	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1410 DORCHESTER ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 11, 1894	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY STOLZENBACH			
14. MOTHER'S MAIDEN NAME MARY W. McKNEW		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE			
16. SOCIAL SECURITY NO. 218-32-3399		17. INFORMANT CHARLES MEYSHAW 6120 MOOREFIELD RD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.7 I DEUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A. C. U. D. (B) _____ (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/11/68 to 11/10/68 that (I) (we) last saw the deceased alive on 11/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John H. Shaw M.D.				23B. DATE SIGNED 11/10/68	
23C. PHYSICIAN'S NAME (Type) John H. Shaw M.D.				23D. ADDRESS 5800 EMMERSON AVE BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-14-68		24C. NAME OF CEMETERY or CREMATORY LONDON PARK	
24D. LOCATION BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR GEO. L. Schwab Funeral Home 1710 N. W. Miller 2101 Frederick Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11361

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOLA Lula S.

HOWARD

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

November 11, 1968

1:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

3. DATE

Pronounced Dead

Month

Day

Year

Hour

November 11, 1968

2:09 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

female

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

3/15/03

10. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2300 Hollins Ferry Road

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jack Stith

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucy

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Odellia S. Hendrickson 2324 Atlantic Ave

19. 571.8 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Fatty Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/12/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/16/68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

Robert E. Ischura

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



NOV 13 1963
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11362				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11362			
1. NAME OF DECEASED (Type or Print) Huston Ingram				2. DATE AND HOUR OF DEATH Nov. 9, 1968 9:00 A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 15-09							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 1105 E. Fayette St.				C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
				E. STREET AND NUMBER 3905 Fairview Ave.							
5. SEX Male		6. RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1888		9. AGE (In years last birthday) 80		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY Florence S.C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Alberta Ballanger 3905 Fair view Ave.					
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				(A) IMMEDIATE CAUSE CVA & rt. hemiparesis DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF:				several yrs.			
(C) _____											
18. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11 - 8 19 67 to November 9 19 68 , that (I) (we) last saw the deceased alive on Nov. 8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Elmer Ellsworth Cook				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 11-12-68			
23C. PHYSICIAN'S NAME (Type) Elmer Ellsworth Cook, M.D.				23D. ADDRESS 2431 Maryland Avenue, Baltimore, Maryland							
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/13/1968		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR William Samuel Hone				ADDRESS 319 N. Schroeder			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11363

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11363

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Louis John Pucci Sr.		2. DATE AND HOUR OF DEATH Nov. 7, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House In The Pines Belvedere 90				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 53-00			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1916	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Starting Gate Inn		9. AGE (In years last birthday) 52 yrs.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Henery Pucci				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-8853		17. INFORMANT Baltimore 7, Md. Mrs. Winifred Pucci, 3407 Vargas Circle			
18. 157.9 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Carcinoma of the Pancreas				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo. 11 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 4, 1968 to Nov. 7, 1968 , that (I) (we) lost the deceased alive on Nov. 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. A. Silver				23B. DATE SIGNED Nov. 8, 1968		23C. PHYSICIAN'S NAME (Type) Abraham A. Silver, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Nov. 9, 1968		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968				25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.	
24D. LOCATION (City, town, or county) (State) Pikesville Maryland							

1872-73

James and George

James and George

James and George

James and George

James and George

1872-73

James and George

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11364

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EDITH ENGLAR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968 6:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968 6:25 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH June 27, 1917		10. AGE (In years last birthday) 51	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administration Assist. Milford Mill E.U.B.		15. MOTHER'S MAIDEN NAME Salome L. Love	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. unknown	
18. INFORMANT Mr. Robert J. Englar, 2378 Glenmount Circle		19. CAUSE OF DEATH Fracture of Neck	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Nov. 8, 1968 5:17 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Driver in auto-auto collision		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 13, 1968	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville Baltio, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Frank H. Newell		25D. ADDRESS Pikesville	

WALLEY & CO. LTD.
25/PAZ 1944

Frank M. Wall

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11365 CERTIFICATE OF DEATH

REG. NO. 68-11365

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Reilly, Harry V.		2. DATE AND HOUR OF DEATH 11/12/68 12:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN PIKESVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 15 SUDBROOK LANE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 23, 1909	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY U.S. MARINE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES HARRY REILLY		14. MOTHER'S MAIDEN NAME KATHERINE COTTEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NON		17. INFORMANT MRS. CATHERINE C. REILLY ADDRESS PIKESVILLE 15 SUDBROOK LANE	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ventricular fibrillation acute myocardial infarction 5 hrs.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest ventricular fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: acute myocardial infarction 5 hrs. (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II					
19A. DATE OF OPERATION 11/12		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED A-V dissociation		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 11/11 19 68 to 11/12 19 68 , that (A) (we) last saw the deceased alive on 11/12 19 68 and that in (B) (our) opinion death occurred on the date and hour and from the causes stated above. (B) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Horvath		23B. DATE SIGNED 11/12		23C. PHYSICIAN'S NAME (Type) Dr. Horvath	
23D. ADDRESS 42 Sinai Hosp		23E. DATE RECEIVED BY HEALTH DEPT. NOV 13 1968			
23F. NAME OF REGISTRAR Robert E. Jenkins		23G. FUNERAL DIRECTOR Frank H. Howard			
23H. ADDRESS MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 15, 1968		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.					

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is subject to change

October 21

Submarine and

Katherine Cottrell

JAMES HARRY KELLY

NC NEW

Submarine and

with expanded up to 10

British Ministry of Defense (Eastern Submarine)

and the Navy

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11366

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN GAMBLE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

November 8, 1968

5:25 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 8, 1968

5:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Feb 29, 1943

10. AGE (In years
last birthday) 25If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1315 W. Fayette Street

11. BIRTHPLACE (State or foreign country)

Williamstown, S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Willie Gamble

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Virginia Mc Gadden

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Janice Mc Gray 2155 Hollins St.

19. E814.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple Traumatic Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

E812.4 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Eastern Blvd. 260' E. of Hartman Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) Nov. 8, 1968 5:05 A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subject struck by car while at work

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 8, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/15/68

24C. NAME OF CEMETERY or CREMATORY

Greenwood Cemetery

24D. LOCATION

(City, town, or county)

Buckeysville

(State)

S. Carolina

25A. DATE REC'D BY HEALTH DEPT.

NOV 13 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Joseph L. Reed

ADDRESS

2122 W. Main Ave.
Baltimore, Maryland

W-256 68-11367 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-11367

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK WAGNER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 12, 1968 Hour: 11:30 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour November 12, 1968 11:55 A.M.			
6. SEX male		7. RACE white		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 23, 1914				10. AGE (In years last birthday) 54		E. STREET AND NUMBER 513 S. Durham Street	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF U.S.A.		13. FATHER'S NAME John Wagner	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Maryanna Rezulak	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 219-03-5778		18. INFORMANT ADDRESS Frances Wagner 513 South Durham Street	
19. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>412.4</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Arteriosclerotic Cardiovascular Disease</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> </div> <div style="width: 45%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
<p>423.1 II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Werner U. Spitz</i> EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968				25B. NAME OF REGISTRAR Robert E. Fodera		25C. FUNERAL DIRECTOR ADDRESS George A. Weber 705 South Ann Street	

WALLEY & FORGE

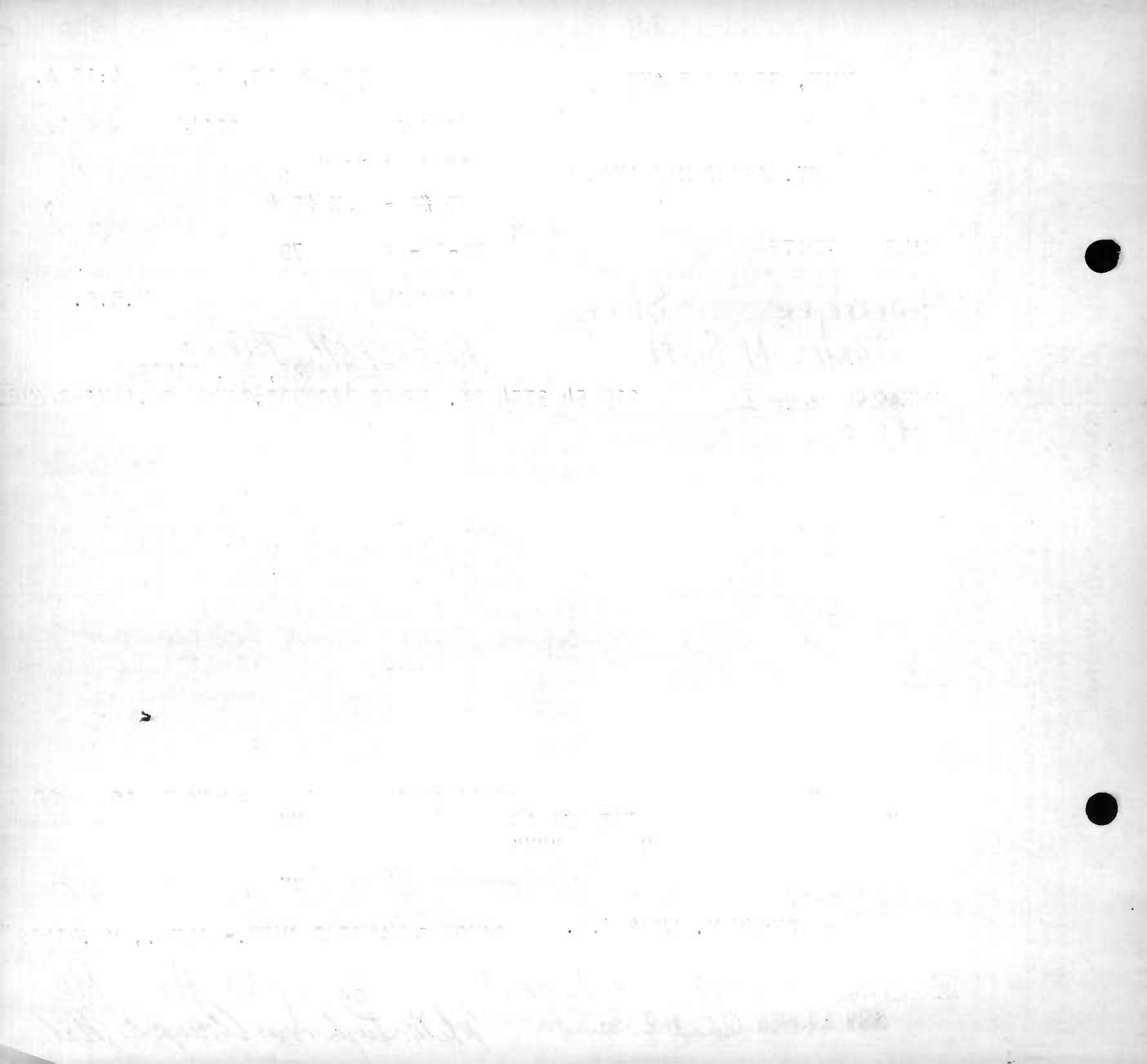
WALLEY PAPER

WALLEY & FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11368
BIRTH NO. 1. NAME OF DECEASED (Type or Print) SUIT, GERARD FRANK		2. DATE AND HOUR OF DEATH NOVEMBER 10, 1968 4:15 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21146 52-00 C. CITY OR TOWN SEVERNA PARK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT #2 - BOX #284		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-26-89	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER		10B. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES M. Syitt		
14. MOTHER'S MAIDEN NAME ELIZABETH TWEES		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN WWI		
16. SOCIAL SECURITY NO. 219 54 3754		17. INFORMANT BALTIMORE, MD. 21229 ST. AGNES RECORDS, CATON & WILKENS AVES		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 150X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 1 1968 to NOVEMBER 10 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOVEMBER 10 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (view) the body after death.				
23A. SIGNATURE Ruben V. Luna		23B. DATE SIGNED 11-10-68		23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA M.D.
23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11-13-68		24C. NAME OF CEMETERY or CREMATORY Hillcrest		24D. LOCATION (City, town, or county) (State) ANNAPOLIS A.H. MD
25A. DATE RECD BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John M. Taylor



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		68-11369	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
James F. Abell				11-11-68 9:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS 52-1-2			
D. STREET ADDRESS (If rural, give location)				1243 TYLER AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
MALE	WHITE	MARRIED	2-20-10	58			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHAUFFEUR		County Govt.		MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
WALLACE ABELL		HANNAH CLARK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				Doris V. Abell #4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
3957 I		PNEUMONIA				30 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO					
421.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		RESPIRATORY INSUFFICIENCY FOLLOWING AORTIC VALVE REPLACEMENT 40 days					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10-2-68		AORTIC STENOSIS		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9-28 11-11 1968 to 11-11 1968 and that (1) (last saw the deceased alive on 11-11 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED					
Sherman G. Souther M.D.		11-11-68					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
SHERMAN G. SOUTHER M.D.		THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		11-14-68		HILLCREST		ANNAPOLIS A.A. MD.	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 13 1968		Robert E. Jenkins		John M. G. L. & Sons		Annapolis, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11370
<div style="display: flex; justify-content: space-between;"> T-100 68-11370 CERTIFICATE OF DEATH </div>					
BIRTH NO. <i>Anne Arundel, Md.</i> 1. NAME OF DECEASED (Type or Print) TUBB BABY GIRL			2. DATE AND HOUR OF DEATH 11-8-68 5-45 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 52-00		
5. SEX F 6. RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-6-68 9. AGE (In years lost birthday) 2 days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New born			10B. KIND OF BUSINESS OR INDUSTRY New BORN		
11. BIRTHPLACE (State or foreign country) ANN ARUNDEL HOSP.			12. CITIZEN OF WHAT COUNTRY? USA-		
13. FATHER'S NAME ROY TUBB			14. MOTHER'S MAIDEN NAME PAMELA GRANDELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. —		
17. INFORMANT Roy Tubb			ADDRESS Lothian Md		
18. 74691 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 254.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-8-68 to 11-8-68 , that (I) (we) lost saw the deceased olive on 11-8-68-5:30 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Maria D. Giaro</i>				23B. DATE SIGNED 11-8-68	
23C. PHYSICIAN'S NAME (Type) MARIA D. GIARO MD				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/68		24C. NAME OF CEMETERY or CREMATORY MT Zion	
24D. LOCATION (City, town, or county) (State) Lothian AA Co Md		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968			
25B. NAME OF REGISTRAR Robert E. Tubb		25C. FUNERAL DIRECTOR Bernard Hardesty			
ADDRESS Hicksville, Md.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W420</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-11371</u>	
1. NAME OF DECEASED (Type or Print) <u>WILLIAM REX WALSH</u>		2. DATE AND HOUR OF DEATH <u>11/12/68</u> <u>9:35</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Ave. Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>53-00</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u> 6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1932</u> 9. AGE (In years last birthday) <u>36 years</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION CO.</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
13. FATHER'S NAME <u>Deairous WALSH</u>		14. MOTHER'S MAIDEN NAME <u>Zenna (4NK)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK.</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>BCH: RECORDS #4940 Eastern Ave. #21224</u>	
18. <u>430.9 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>SUB-ARACHNOID HEMORRHAGE</u> <u>3 days</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>2 RUPTURED BERRY ANEURYSM</u> <u>3 days</u>			
330X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/9/68</u> 19 <u>68</u> to <u>11/12</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph Kaplan</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/12/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph Kaplan</u>		23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Ave. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-16-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>NO. WILKES BARRE CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>NO. WILKES BARRE, N.C.</u>					
25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 13 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Lilly & Zeiler, 1901 Eastern Ave., Balto. Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 4-620		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11372	
1. NAME OF DECEASED (Type or Print) WALTER T. HERRICK			2. DATE AND HOUR OF DEATH 11/8/68 12:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland 21205 B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1800 Hoffman Street 21205		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1901	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die Maker		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Herrick		
14. MOTHER'S MAIDEN NAME Cora Diamond			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 213-07-2184-A			17. INFORMANT Records: BCH-4940 Eastern Avenue 21224		
18. 157-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastases to brain CA of stomach.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10-23 19 68 to 11/8 19 68 , that (I) (we) lost saw the deceased alive on 11/8 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip A. Fraterriego, MD				23B. DATE SIGNED 11/8/1968	
23C. PHYSICIAN'S NAME (Type) Philip Fraterriego MD				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland Baltimore City Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 12 1968		25B. NAME OF REGISTRAR Robert E. Schimunek		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

CA of 17th Street
Collectors to know
Cincinnati, Ohio

11/18 11/18 11/18

Philip A. Fritzsche, MD
Philip A. Fritzsche, MD
Philip A. Fritzsche, MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-11373
BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS IDA L.		2. DATE AND HOUR OF DEATH 11-8-68 8:16 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 36		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-82 9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 282 101		17. INFORMANT Blanch N. Herget, dght. above
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Breast, Right		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170 X II Arteriosclerotic Heart Disease		(B) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10-13-1968 to 11-8-1968 , that (I) (we) last saw the deceased alive on 11-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE P. Barrola M.D.		23B. DATE SIGNED 11-8-68		23C. PHYSICIAN'S NAME (Type) PABLO R. IBARROLA
23D. ADDRESS FRANKLIN SQUARE HOSP		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11/12/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Blanch N. Herget		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.
				ADDRESS 3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-11374		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11374	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SCHULTZ, ELSIE G.			2. DATE AND HOUR OF DEATH Nov. 8, 1968 4:49 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If not in city limits, give location) Bradshaw Pfeiffer Pfeiffer Road		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/13/05	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JOHN GREEN			14. MOTHER'S MAIDEN NAME EMMA WEISNER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-54-7435	17. INFORMANT ADDRESS Edward F. Schultz, husband, above		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day					
18. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Heart Block					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Nov 11-8 1968 to Death 11-8 1968, that (I) (we) last saw the deceased alive on 11-8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gottlieb C. Friessinger			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-8-68
23C. PHYSICIAN'S NAME (Type) GOTTLIEB C. FRIESSINGER, M.D.			23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/12/68	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968	25B. NAME OF REGISTRAR Robert E. Schumaker	25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

Mr. J. H. H. H. H.

20-11-11

James H. H. H. H.
H. H. H. H. H.
2/12/02

That H. H. H. H. H.

H. H. H. H. H.
No

11-8-11

11-8-11

11-8-11

H. H. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11375

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MURPHY, MARGARET ANN		2. DATE AND HOUR OF DEATH November 8, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		8. DATE OF BIRTH 12/8/1888 9. AGE (In years last birthday) 79 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Joseph Fermes		14. MOTHER'S MAIDEN NAME Catherine Fermes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-2679D		17. INFORMANT 3108 Hillcrest Ave. ADDRESS 21234 Joseph Finn, Sr. nephew	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myemia (B) Coronary-Vascular Hypertensive Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 443X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 20, 1968 to Nov. 8, 1968 , that (I) was last saw the deceased alive on Nov. 8, 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Dausch		23B. DATE SIGNED 11-9-68		23C. PHYSICIAN'S NAME (Type) Michael J. Dausch, M.D. Dr. Michael J. Dausch	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/12/68		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. ADDRESS (State)			

FUNERAL DIRECTOR: IMPORTANT

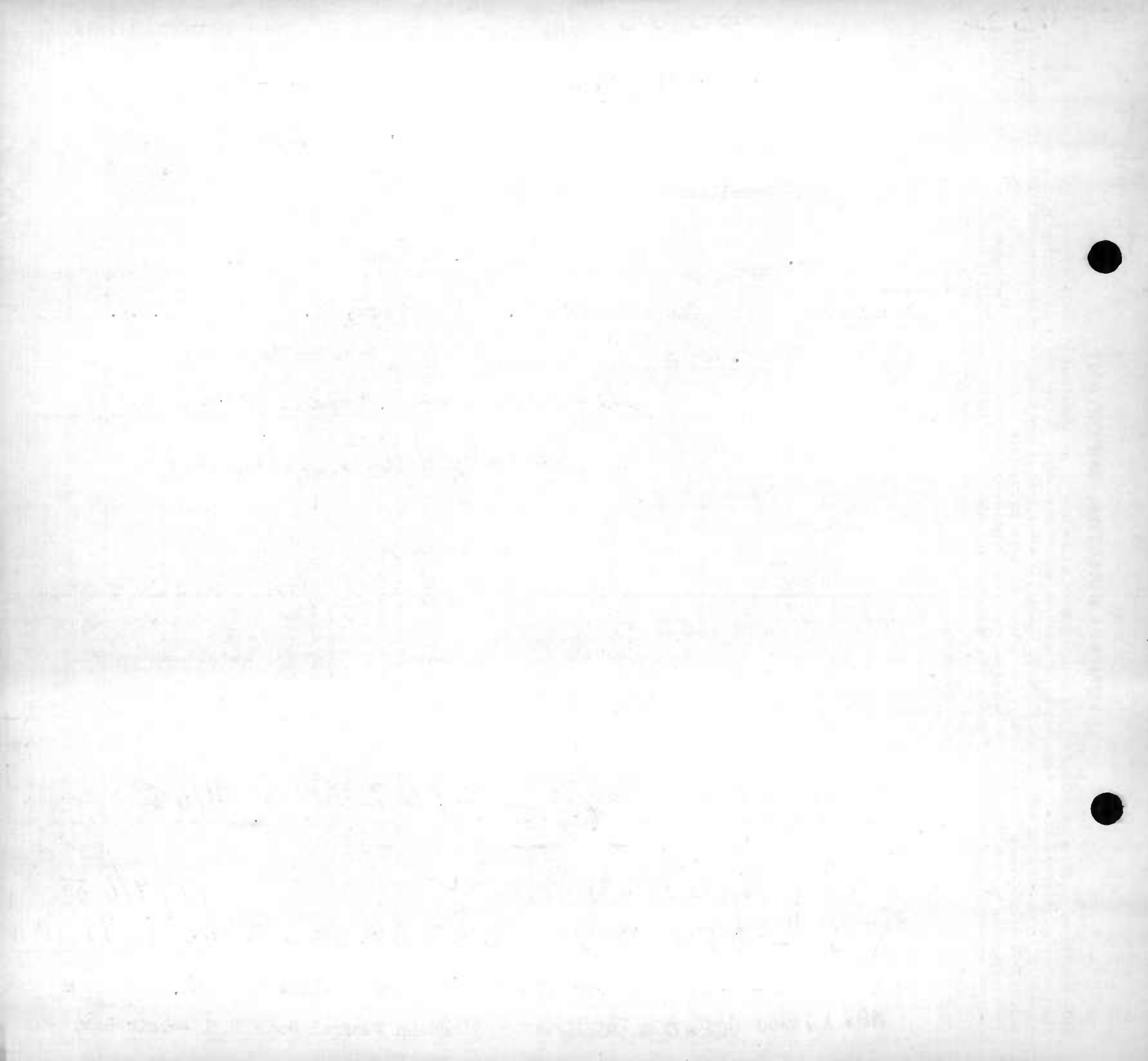
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11376

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68-11376

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Henry Christian Franz		11- 7- 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 4515 Powell Avenue				Md. 260	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4515 Powell Avenue 6	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days 11 Under 24 Hrs. Hours; Min.
Male	Cau.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2- 8- 1898	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Electrician		Gas & Electric Co.		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John C. Franz			Anna Emelie Iling		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW I		212-00-3990		Edward H. Franz 41 Cliffwood Road 6	
18. 44091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Generalized Atherosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/67 19 to 11/68 19, that (I) (we) last saw the deceased alive on 11/8/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE D. J. Lyden M.D.				23B. DATE SIGNED 11/9/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
R. J. LYDEN M.D.				6402 GOLDEN RING RD BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		11-11-1968		Gardens of Faith Cemetery	
				Baltimore Co. M	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 13 1968		Robert E. J. Lyden		Lassahn Funeral Home 7401 Belair Road	



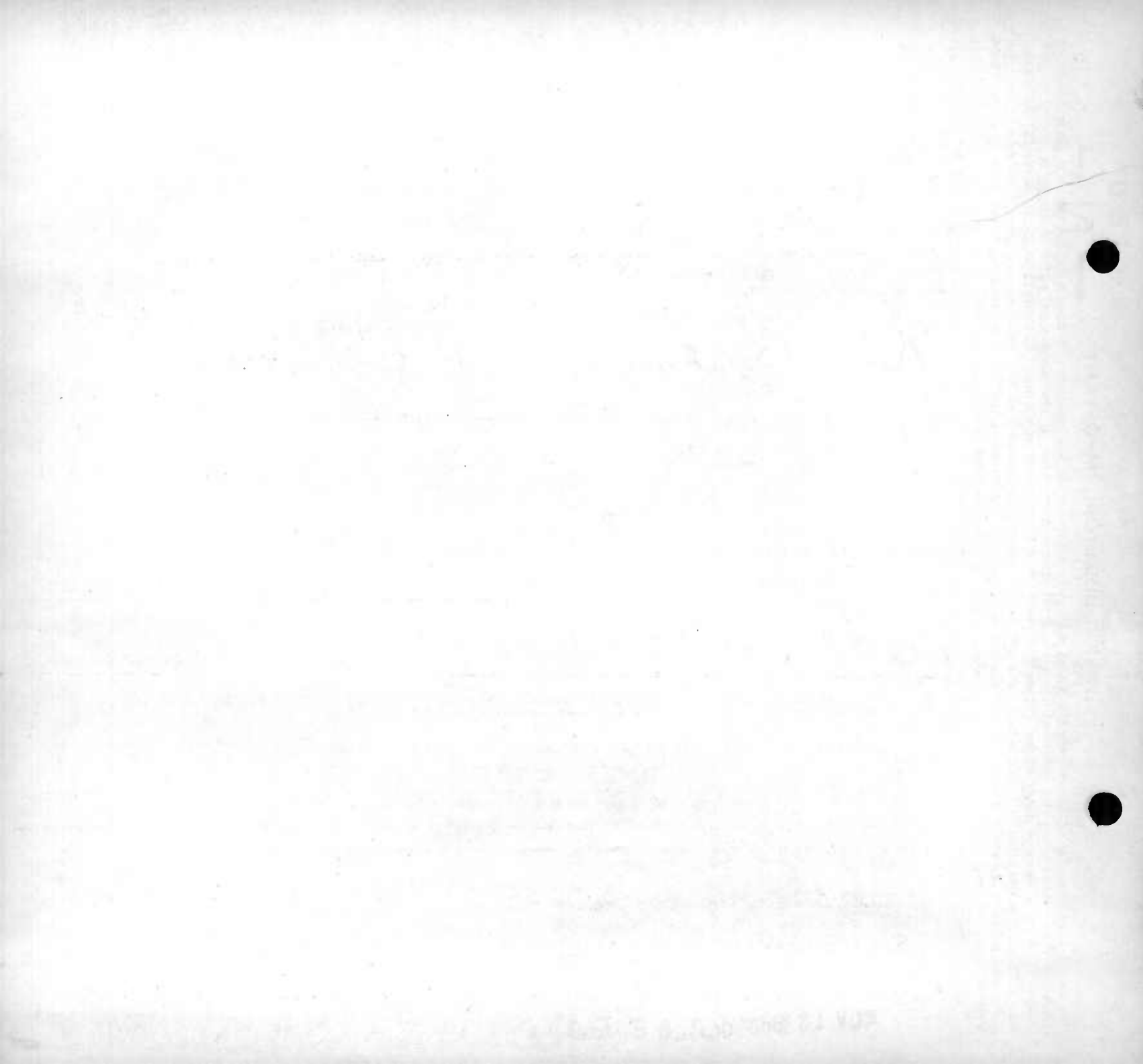
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11377 CERTIFICATE OF DEATH

REG. NO. 68-11377

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Hedmar Buckmann		2. DATE AND HOUR OF DEATH 11/8/68 4⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Balt. Md. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired welder steel mill		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-25-96 9. AGE (In years lost birthday) 72	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nels Buckmann	
14. MOTHER'S MAIDEN NAME Hedvig Sorensen		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 100-09-1204	
17. INFORMANT Frank Buckmann		ADDRESS Baltimore Md.		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tumor of liver, prob. metastatic				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis of liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10-30-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-30-68 to 11-8-68 , that (I) (we) last saw the deceased alive on 11-8-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley R. Weiner M.D.				23B. DATE SIGNED 11-8-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS South Baltimore General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-10-68		24C. NAME OF CEMETERY or CREMATORY St. Louis Cemetery	
24D. LOCATION (City, town, or county) Clarksville Md.		24E. STATE Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968	
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Donald J. H. Fairbank		25D. ADDRESS Baltimore Md.	



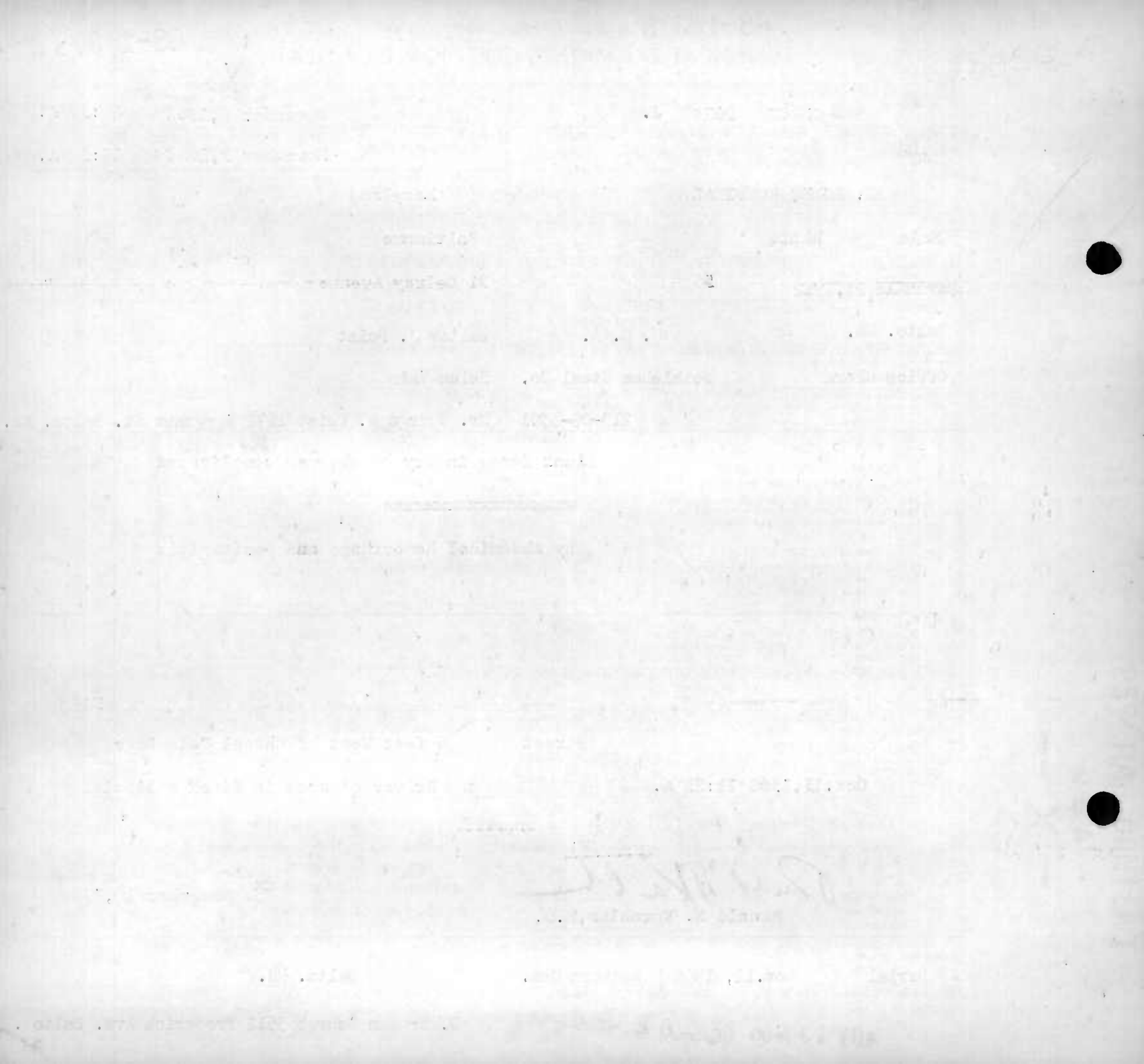
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11378

BIRTH NO.

REG NO

1. NAME OF DECEASED (Type or Print) GEROGE POIST J.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 9, 1968 Hour 10:50 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 9, 1968 Hour 10:50 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 21, 1912		10. AGE (In years lost birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk		14B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-09-3391	
15. MOTHER'S MAIDEN NAME Helen Vain		18. INFORMANT Mr. George W. Poist 1272 Sargeant St. Balto. Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 815.0 Blunt force injury to abdomen complicated		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 819.4 II by abdominal hemorrhage and peritonitis		DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Oct. 17, 1968 11:35 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6 feet West of Chapel Gate Lane		22F. HOW DID INJURY OCCUR? Driver of auto in fixed collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED November 10, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 12, 1968	
24C. NAME OF CEMETERY or CREMATORY Western Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Indovina	
25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto.		ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE MOXLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 9, 1968 8:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 9, 1968 8:15 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Dec. 30, 1923	10. AGE (In years lost birthday) 44	11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Cornelius Moxley	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		14B. KIND OF BUSINESS OR INDUSTRY Truck Co.	
15. MOTHER'S MAIDEN NAME Beatrice Reilly			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 1943-1946		17. SOCIAL SECURITY NO. 216-16-8526	
18. INFORMANT Mrs. Beatrice Moxley		ADDRESS 445 Yale Ave. Balto. Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of Liver		CAUSE OF DEATH Cirrhosis of Liver	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 3-8-70		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 3-8-70			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (Partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED November 10, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 13, 1968	
24C. NAME of CEMETERY or CREMATORY Loudon National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave. Balto.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11380

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WILLIAM B. WEINERS SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 10, 1968 3:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1608 Abbotston Avenue 11-15-68		3. DATE PRONOUNCED DEAD Month Day Year Hour November 11, 1968 12:47 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 17, 1906		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Cab Co	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-09-13025	
18. INFORMANT Weiners		ADDRESS William B Weiner Jr. 1708 Wadsworth Way	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11/11/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68	
24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. Fiedler	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		ADDRESS Baltimore, Maryland	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11381 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-11381

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Timothy J. Shanahan		2. DATE AND HOUR OF DEATH 11-11-68 7:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 10-D	
5. SEX m		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-25-84		9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance	
11. BIRTHPLACE (State or foreign country) Baito - Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John J. Shanahan	
14. MOTHER'S MAIDEN NAME ANNA J O'CONNOR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-3 489	
17. INFORMANT Mrs Eleanor Kearney 5425 Masfield Rd		18. 560.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, Postop		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
19. 570.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Congestive heart failure		20. 17 days Acute bowel obstruction		17 days	
21. 17 days Multiple adhesions		22. 24 hrs		23. 24 hrs	
19A. DATE OF OPERATION 3 10-25-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10:20 19 68 to 11-11 1968 that (1) (we) lost saw the deceased alive on 11-11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Hamby M.D.		23B. DATE SIGNED 11-12-68		23C. PHYSICIAN'S NAME (Type) J. Hamby M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY St John's Long Green	
24D. LOCATION Hydes Maryland		24E. NAME OF REGISTRAR Robert E. Fisher		24F. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. T-200		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11382	
1. NAME OF DECEASED (Type or Print) William Thiess			2. DATE AND HOUR OF DEATH 11/13/68 1:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 3-2-06
13. FATHER'S NAME JOHN Thiess			14. MOTHER'S MAIDEN NAME MATILDA Revel		9. AGE (In years last birthday) 62 If Under 1 Yr. Months: Days: Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-07-0423		12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE #21224			ADDRESS		
18. 5272 II DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE COPD DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 11-12 19 68 to 11-13 19 68 , that (1) (we) last saw the deceased alive on 11-13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul Kalkut M.D.					23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) PAUL KALKUT M.D.					23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Mt Olivet	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 13 1968		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Leonard J. Buck Inc.	
25D. ADDRESS Baltimore, Maryland		25E. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.				68-11383	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FRANCES Schepf		11-12-68 6:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
90 Little Srs. of The Poor 1200 VALLEY ST 21202		Maryland 10-01			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1200 VALLEY ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-17-1876	92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Austria	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
FRANK OTENASEK		Josephine Trost			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-10-9219D		Little Srs. of The Poor	
18. 412.41		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		cardiac failure			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic disease			
		(C) Generalized arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 11-11-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Justin Kudirka				11.13.68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Justin Kudirka				2151 Wilkens Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/15/68		Holy Redeemer	
				Baltimore	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 14 1968		Robert E. Fudyma		Philip Herwig Sons	
				ADDRESS 2024	

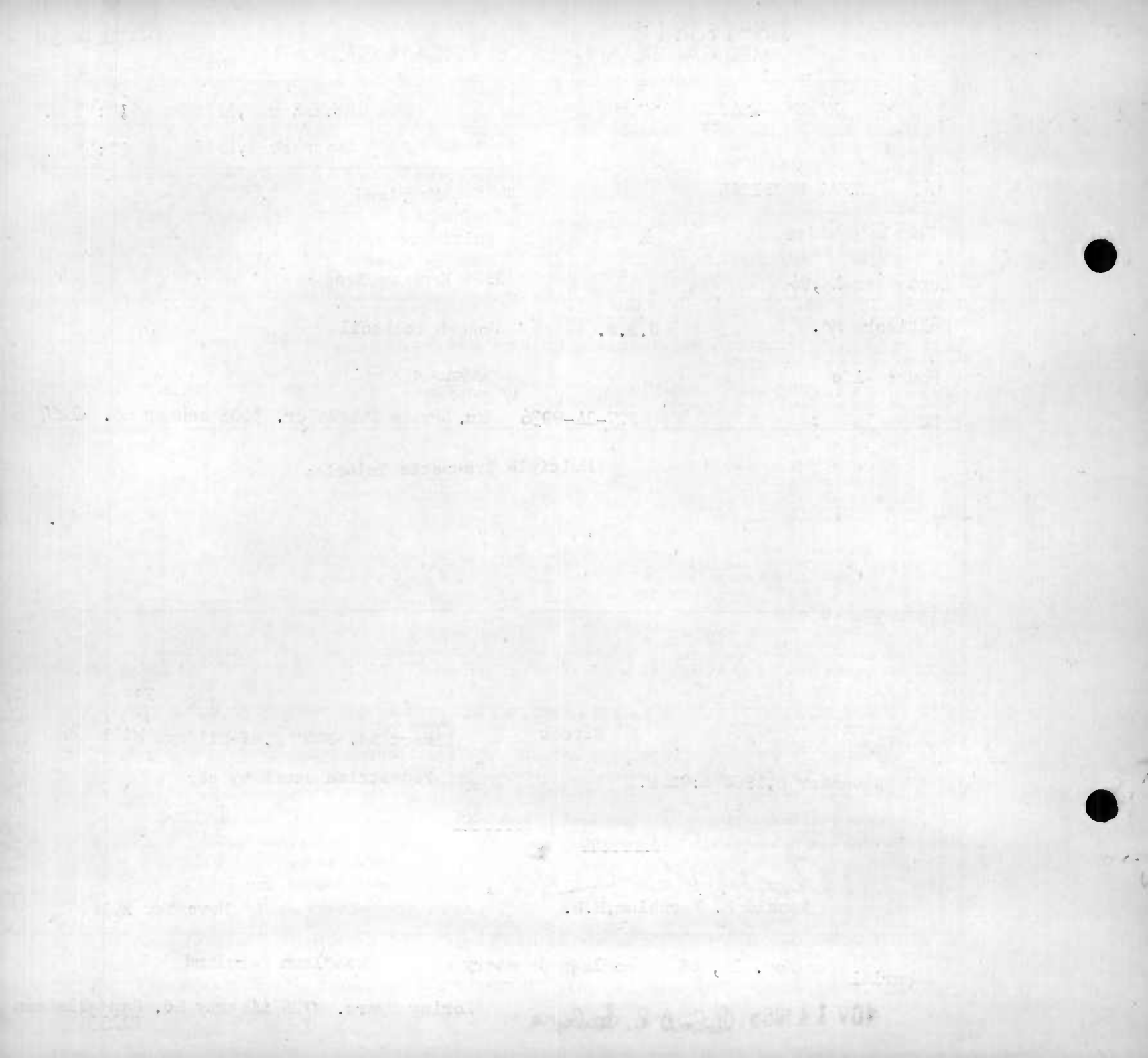
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11384

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARY STRASKA STASKA		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 9, 1968 12:11 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year November 9, 1968 12:11 A.M.	
6. SEX Female		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH September 14, 96		10. AGE (In years last birthday) 72-66	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Joseph Poskocil	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Unknown Josephine Cerny		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 227-14-9936		18. INFORMANT ADDRESS Mr. James Staska Jr. 3605 Kenmar Rd. 21207	
19. E814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION E812.4		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Libert Rd. 300' E. of Milford Mill Road	
22D. TIME (Month) (Day) (Year) (Hour) November 8, 1968 8:02		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Pedestrian stuck by car		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 9, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 12, 68	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D. BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jarboe	
25C. FUNERAL DIRECTOR Loring Byers. 8728 Liberty Rd. Randallstown 21133		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11385 CERTIFICATE OF DEATH

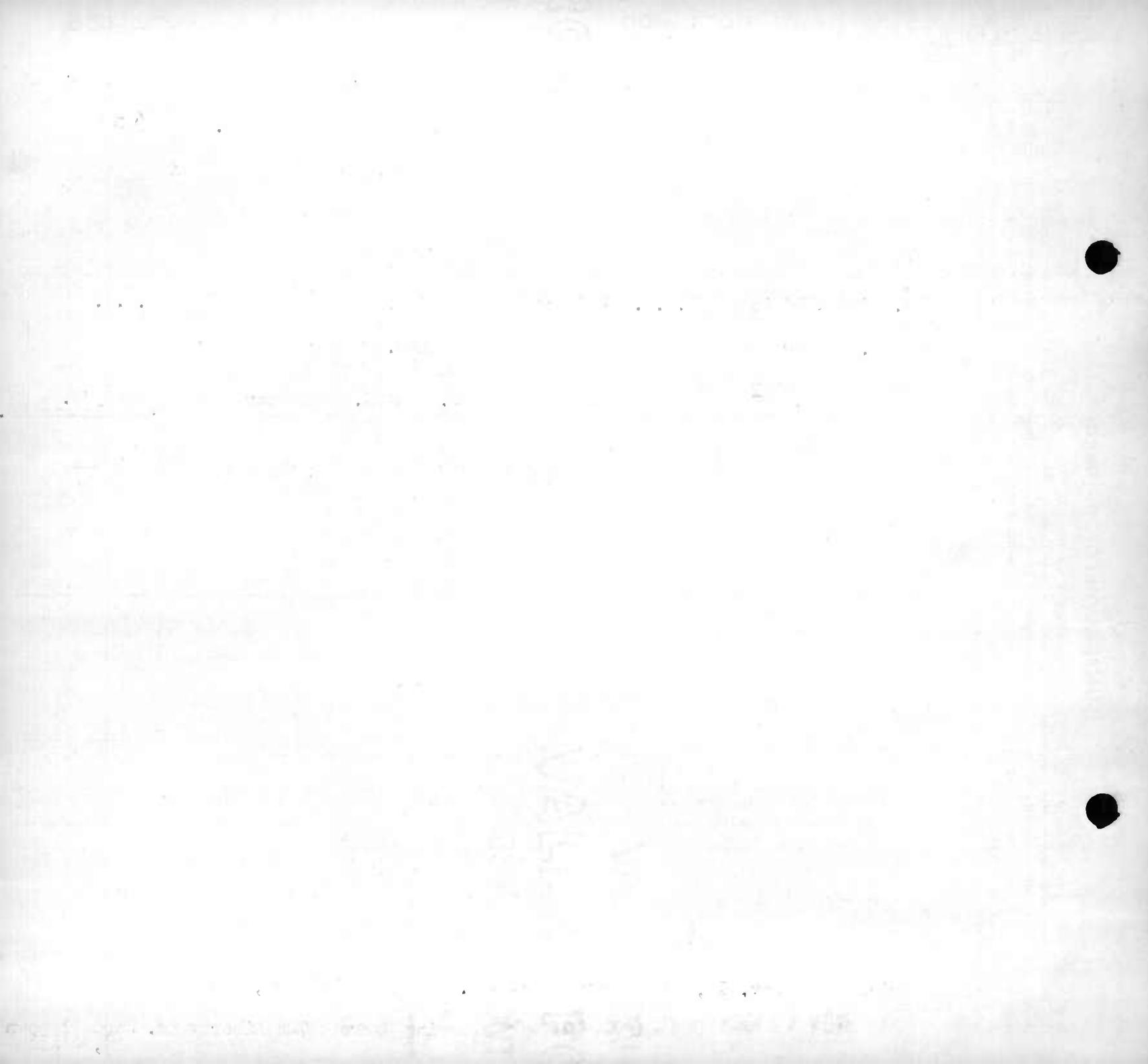
REG. NO. 68-11385

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH OR GUISEPPI BIANCUCCI		2. DATE AND HOUR OF DEATH 11/11/68 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) RES. 2314 E. BALTO. ST.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2314 E. BALTO. ST.		
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 27th. 1892 AGE (In years, months, days) 78 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done or most important part of life, or retired) PIPE BENDER. STEEL			10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) ITALY
13. FATHER'S NAME VINCENZO BIANCUCCI			14. MOTHER'S MAIDEN NAME FILOMENA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-08-3356		17. INFORMANT MRS. MARIA BIANCUCCI 2314 E BALTO. ST	
18. CAUSE OF DEATH 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic heart disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS. (B) DUE TO, OR AS A CONSEQUENCE OF: BRONCHITIS - CHRONIC - BRONCHIECTASIS. (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 420.0 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1961 19 to NOV 11 19 68 , that (I) (we) last saw the deceased alive on Oct 7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME ANDREW LIMISCHKA 2608 E. BALTO ST.				23B. DATE SIGNED Nov 12-1968 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23D. ADDRESS BALTO. Md.		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/14/68		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER \$34.00 BELAIR RD. BALTO. Md.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE RECEIVED BY HEALTH DEPT. NOV 14 1968			
25B. NAME OF REGISTRAR Robert E. Tschuma		25C. FUNERAL DIRECTOR Frank Polyzoske			
25D. ADDRESS 322 S HIGH ST.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11386				BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-11386	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Theodore R. Patterson</u>				2. DATE AND HOUR OF DEATH <u>11/10/68</u> <u>4:50 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore.</u> <u>53-00</u>			
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12/18/15</u> 9. AGE (In years last birthday) <u>53</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tec. Lieson Officer</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>N.S.A. Airforce</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
13. FATHER'S NAME <u>June R. Delker Walter Patterson</u>				14. MOTHER'S MAIDEN NAME <u>June R. Delker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give dates of service) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>213-01-7345</u>		17. INFORMANT <u>Mrs. June R. Patterson</u> ADDRESS <u>3506 Chapman Rd. Randallstown Md.</u>	
18. <u>400.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Malignant Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>	
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>445X II</u>				20A. AUTOPSY? (Yes or No) <u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <u>11/8/68</u> 19 to <u>11/10/68</u> 19, that (I) (we) last saw the deceased alive on <u>11/10/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Barton A. Cohen</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Barton A. Cohen</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Nov. 14, 68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 14 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Loring Byers</u> ADDRESS <u>8728 Liberty Rd. Randallstown Md.</u>	



w-630

68-11387 BALTIMORE CITY HEALTH DEPARTMENT

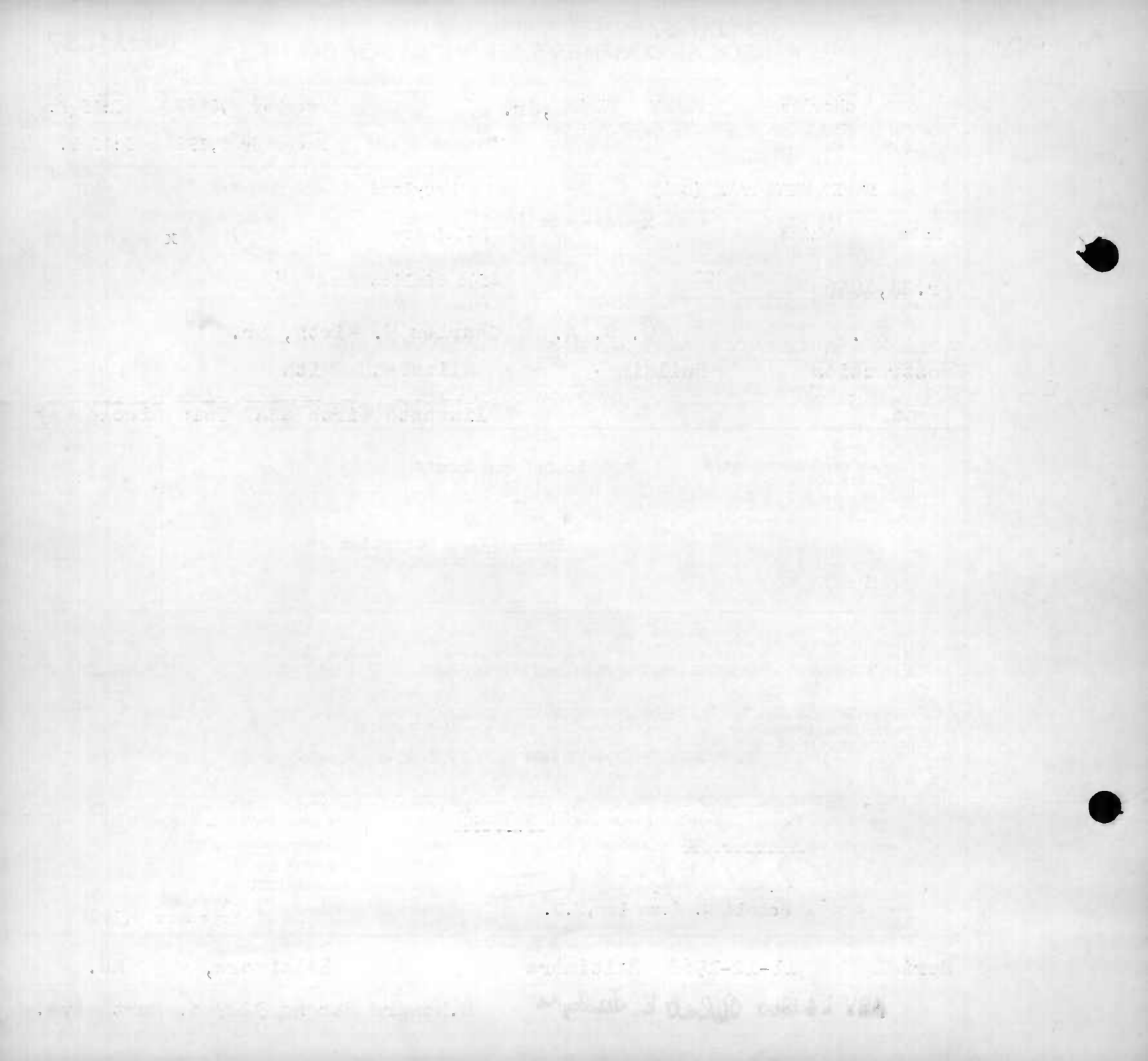
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11387

BIRTH NO.

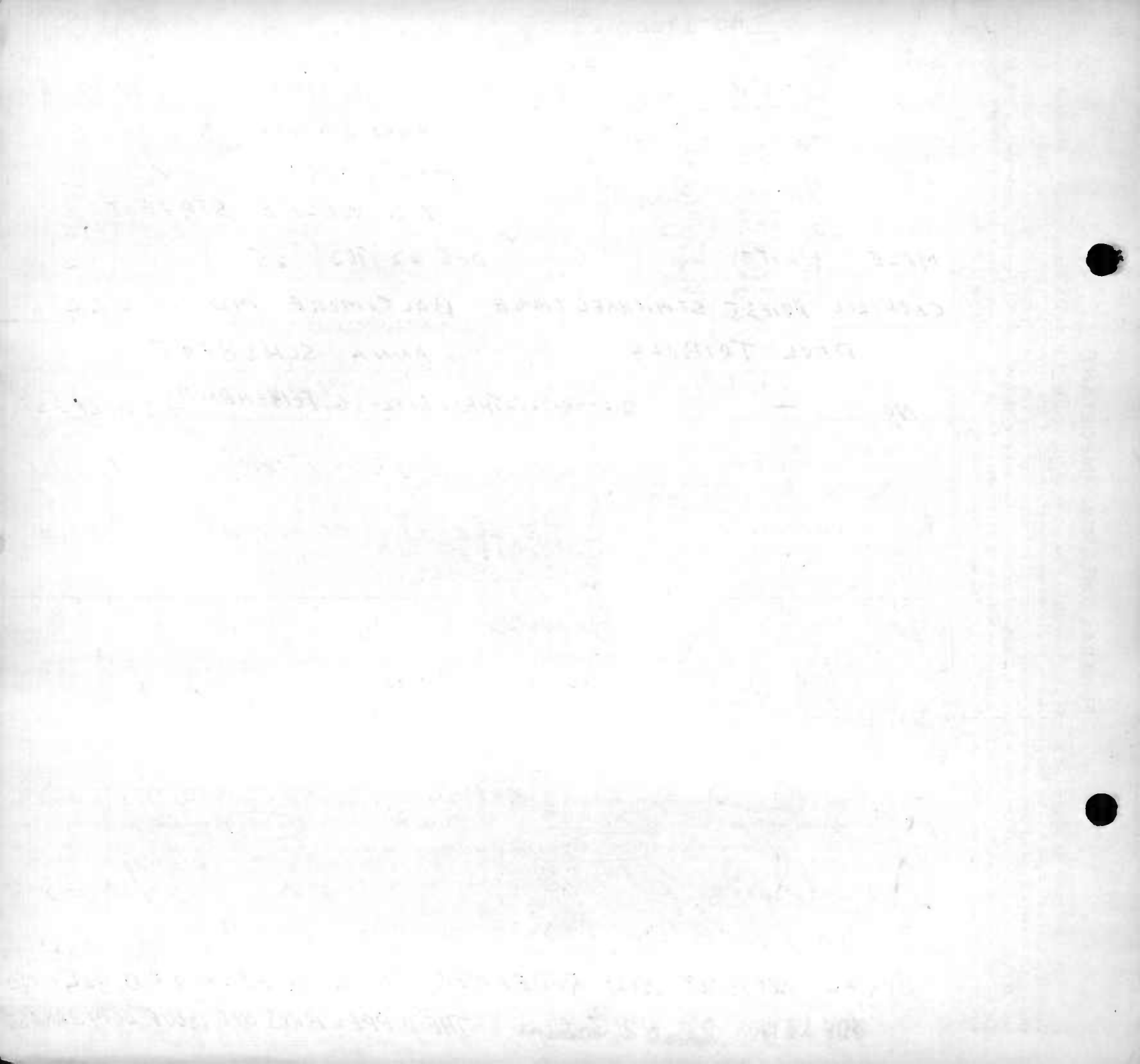
1. NAME OF DECEASED (Type or Print) Charles HENRY WIRTH, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 8, 1968 Hour 5:15 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 DRUID HILL PARK (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 8, 1968 Hour 5:15 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? 27 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Apr. 28, 1946	10. AGE (In years lost birthday) 22	E. STREET AND NUMBER 4546 Pimlico Road	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		13. FATHER'S NAME Charles H. Wirth, Sr.	
14B. KIND OF BUSINESS OR INDUSTRY Building		15. MOTHER'S MAIDEN NAME Elizabeth Smith	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Elizabeth Wirth		ADDRESS 4247 Twin Circle Way	
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intravenous Narcotism (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 323X		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 9, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-12-1968	24C. NAME of CEMETERY or CREMATORY Baltimore	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968	25B. NAME OF REGISTRAR Robert E. Barkley	25C. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-614		68-11388		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11388	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) FATHER JOHN TRIBULL			
2. DATE AND HOUR OF DEATH 11/9/68 10:10 P M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2-01				5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER 7 S WOLFE STREET				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			
7. SEX MALE		8. RACE WHITE		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH DEC 22 1902 65	
11. AGE (In years last birthday)		12. If Under 1 Yr. Months: Days		13. If Under 24 Hrs. Hours: Min.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATHOLIC PRIEST	
15. KIND OF BUSINESS OR INDUSTRY ST MICHAEL CHURCH		16. BIRTHPLACE (State or foreign country) BALTIMORE MD		17. CITIZEN OF WHAT COUNTRY? USA.		18. FATHER'S NAME PAUL TRIBULL	
19. MOTHER'S MAIDEN NAME ANNA SCHUBERT		20. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) NO		21. SOCIAL SECURITY NO. 216-38-2454		22. INFORMANT TREV. CHARLES G. FEHRENBACH	
23. ADDRESS 7 S WOLFE ST		24. CAUSE OF DEATH Peritonitis		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days		26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Perforated duodenal ulcer	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes		29. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 3 10/30/68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED peptic ulcer 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Oct. 24 1968 to Nov. 9 1968 , that (I) (we) last saw the deceased alive on Nov. 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE David S. McHold MD		23B. DATE SIGNED 11/10/68	
23C. PHYSICIAN'S NAME (Type) DAVID S. MCHOLD MD		23D. ADDRESS MERCY HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV 13 1968	
24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM		24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BALTO MD		25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR THE DIPPEL BROS INC		25D. ADDRESS 1800 E LOMBARDO ST		VS 150-REV. 1/1/68			



FUNERAL DIRECTOR: IMPORTANT

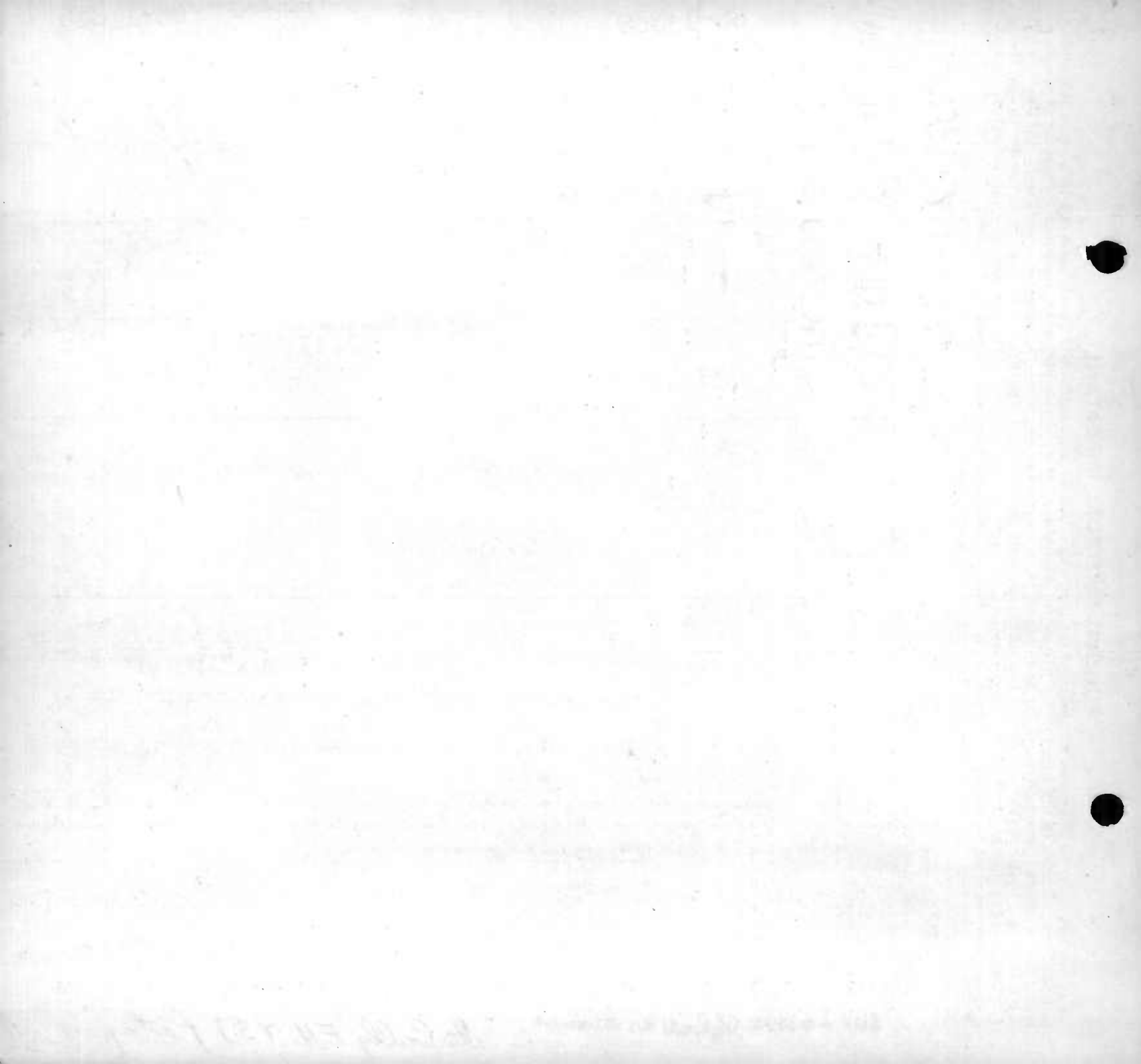
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11389

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11389

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>COOK, MAYME I.</u>		2. DATE AND HOUR OF DEATH <u>11-13-68</u> <u>4 40</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>43</u> <u>South Balto. General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> - CITY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>613 E. FORT AVE</u>		
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-92</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>WALTER S</u>		
14. MOTHER'S MAIDEN NAME <u>KATHRYN ? (DEC)</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>214-01-7521-B</u>			17. INFORMANT <u>HUSBAND</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>73601</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/10 yrs</u>			19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 12</u> 19 <u>68</u> to <u>Nov 13</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 13</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) <u>view the body after death.</u>					
23A. SIGNATURE <u>Robert A. Rosenfeld for M.D.</u>			23B. DATE SIGNED <u>11/13/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert A. Rosenfeld</u>
23D. ADDRESS <u>SOUTH BALTIMORE GEN. HOSP</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>11/16/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Mem Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
25A. DATE REG'D BY HEALTH DEPT. <u>NOV 14 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>McCallie F.H. 737 Patapasc ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11390
BIRTH NO. <u>Balto. Co. Md.</u>		68-11390 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LAUREN L. GIESLER</u>			2. DATE AND HOUR OF DEATH <u>11-10-68</u> <u>9:53P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>601 NORTH BROADWAY</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto. 7</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>6811 ALTER STREET, 21207</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-68</u>	9. AGE (In years last birthday) <u>8</u> <u>8</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HARRY GIESLER</u>		14. MOTHER'S MAIDEN NAME <u>MARIE LAUTERBACH</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Mr. Harry W. Giesler Jr. 6811 Alter St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PERITONITIS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHOLECYSTJEJUNOSTOMY</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>BILIARY ATRESIA</u>		
			(C) <u>CIRRHOSIS of the LIVER</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>75-6.2 II</u>					
19A. DATE OF OPERATION <u>11/5/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BILIARY ATRESIA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>10/28</u> <u>1968</u> to <u>11/10</u> <u>1968</u> , that we (we) last saw the deceased alive on <u>11/10</u> <u>1968</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE <u>James R. K. Condon M.D.</u>				23B. DATE SIGNED <u>11/10/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAMES R. CONDON, M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 14, 68</u>		24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>	
24D. LOCATION <u>Liberty Rd. Baltimore County</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 14 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Loring Byers 8728 Liberty Rd. Randallstown</u>			

11/2/08 BILARY ATRESIA YES
 CIRCUMCISED WITH RIVER
 BILARY ATRESIA
 CHOLECYSTECTOMY
 PETITITIS

James R. K. Cowder MD
 11/10/08
 10/5/08
 11/10/08
 11/10/08

1
B-260

68-11391

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11391

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS IGNATIUS BUSER

2. DATE
OF DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

November 12, 1968

8:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

3. DATE
PRONOUNCED DEAD

November 12, 1968

9:14 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Harford

62-00

6. SEX

male

7. RACE

white

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Joppa

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 1, 1951

10. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

423 Philadelphia Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward J. Buser, Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

High School

15. MOTHER'S MAIDEN NAME

Ida R. Langley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

213-60-7409

18. INFORMANT

ADDRESS Joppa, Md.

Edward J. Buser, Sr., 423 Philadelphia Road,

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH

Contusion of Chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Joppa Rd. & Route 40 (intersection)

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 11/12/68 8:00 A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in car in-
volved in collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/12/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov. 15, 1968

24C. NAME OF CEMETERY or CREMATORY

Bel Air Memorial Gardens

24D. LOCATION (City, town, or county)

Bel Air

(State)

Harford Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

25B. NAME OF REGISTRAR

Robert E. Jones, M.D.

25C. FUNERAL DIRECTOR

Howard K. McComas & Son, Abingdon, Md.

1891-2

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11392

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-11392

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Drucilla K. Lutz

2. DATE AND HOUR OF DEATH

11-9-68

18:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN

Lutherville

E. STREET AND NUMBER

13 Thornhill Road

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-27-01

9. AGE (In years lost birthday)

67

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Kelley

14. MOTHER'S MAIDEN NAME

Margaret Green

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Family records

ADDRESS

18. *174X I*

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Metastasis

(B) DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of Breast

(C) DUE TO, OR AS A CONSEQUENCE OF:

Bone Metastasis

170X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Liver metastasis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from *10-13* *1968* to *11-9* *1968*, that ~~the~~ (we) last saw the deceased alive on *10-8* *1968* and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~We~~ (We) (did) ~~did not~~ view the body after death.

23A. SIGNATURE

John Kelley

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-9-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DEGREE

2511-D Steele Rd Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Nov. 12, 1968

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION

Pikesville, Maryland

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

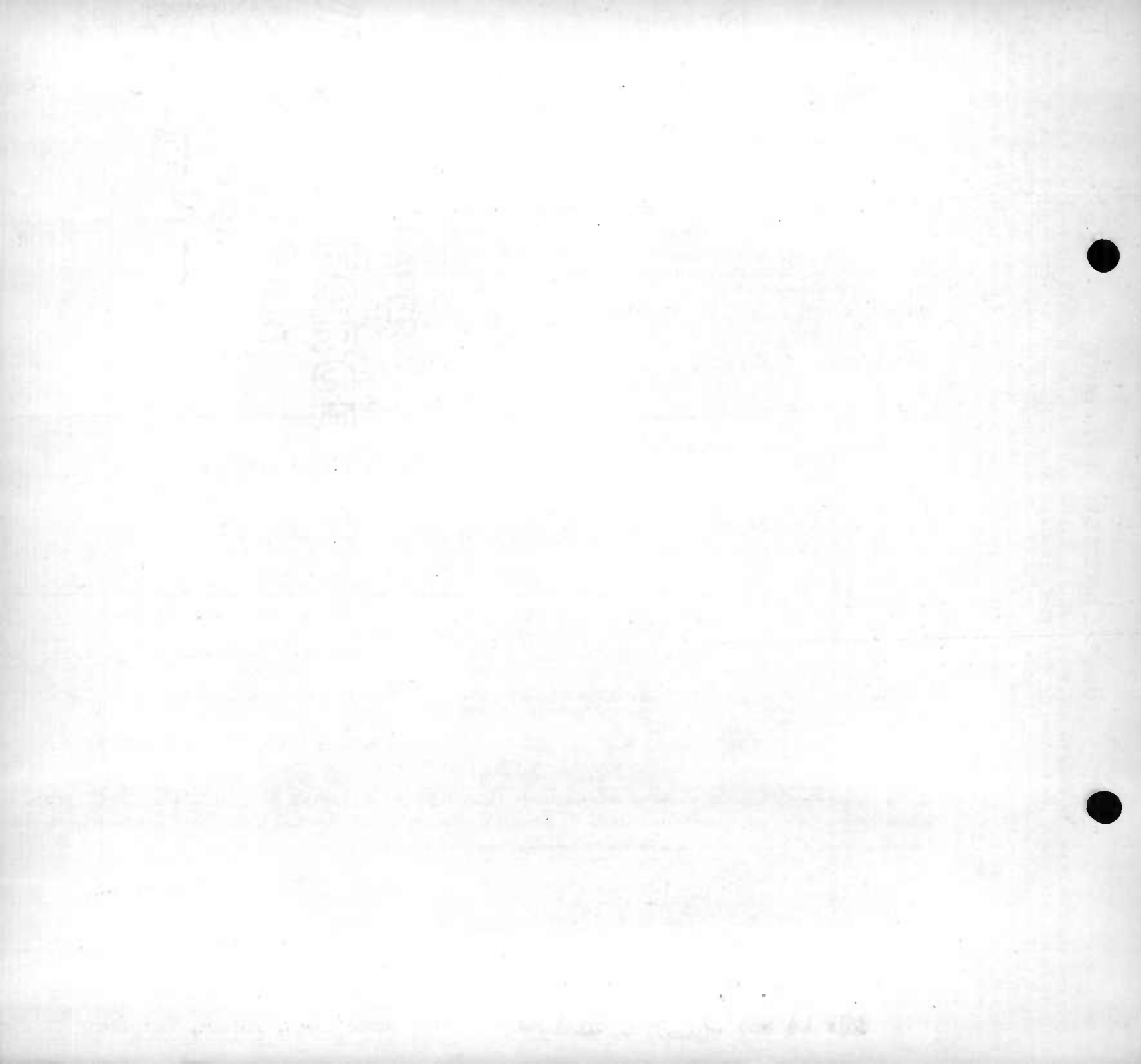
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

John Burns' Sons, Towson, Maryland

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11393

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11393

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lois C. Kramer</i>		2. DATE AND HOUR OF DEATH <i>November 7, 1968 12:10 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>13-08</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Ardleigh Nursing Home</i>			C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>Ardleigh Nursing Home</i>		
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 16, 1898</i>	9. AGE (In years lost birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Charles A. Cummings</i>			14. MOTHER'S MAIDEN NAME <i>Elara S. Jones</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-20-6600</i>	17. INFORMANT <i>Frank J. Kramer</i> ADDRESS <i>123 Stahl Ave. Balto., Md.</i>		
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Parkinson's syndrome</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Osteoarthritis of spine</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>422.1 II</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> <i>2 yrs.</i> <i>4 yrs.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 17, 1968</i> to <i>November 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>November 6, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>				23B. DATE SIGNED <i>Nov. 8, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor M.D.</i>				23D. ADDRESS <i>3902 Greenmount Avenue</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-11-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olive Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Randallstown, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 14 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Saylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Tichner & Sons</i> ADDRESS <i>Balto., Md.</i>	

No
 Charles A. Cummings
 Housewife
 F. White
 ✓
 Maryland
 1870

Burial 11-11-08 Mt. Olive Cem.
 Randallstown, Md.
 Wm. F. T. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11394 CERTIFICATE OF DEATH

REG. NO. 68-11394

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>FLOWERS MARGARET W</i>		2. DATE AND HOUR OF DEATH <i>11-9-68 4:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hospital of Maryland</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1235 Maiden Lane</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-19-90</i>	9. AGE (In years last birthday) <i>78 yrs</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>FREDERICK BRANDT</i>			14. MOTHER'S MAIDEN NAME <i>SOPHIE RADECKE</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS E.T. WOOTEN</i> <i>1235 MAIDEN LANE</i>
18. <i>431.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Coronary vessel accident</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>—</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>331X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-8-68</i> to <i>11-9-68</i> , that (I) (we) last saw the deceased alive on <i>11-9-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. Mathiprakasham</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>G. MATHIPRAKASHAM M.D.</i>				23D. ADDRESS <i>Lutheran Hospital of Maryland</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-11-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>LOUN DAY PARK</i>	
24D. LOCATION <i>BALTIMORE MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 14 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Wm. H. Decker & Sons Inc</i>			

1932 JAN 10
RECEIVED
FREDERICK BARNETT

FREDERICK BARNETT
H.C.

RECEIVED
FREDERICK BARNETT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11395 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11395

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HAWVER EDYTH G.		11-1-1968 5-40P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1501 DUKELAND ST. (DUKELAND NURSE A/G HOME)	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-3-1983	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-99-3129		17. INFORMANT M. Wm. A. Hawver. Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic brain syndrome (C) Abdominal tumor			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9-17-1968 to 11-1-1968, that (X) (we) last saw the deceased alive on 11-1-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE P. P. JOSHI MD				23B. DATE SIGNED 11-1-68	
23C. PHYSICIAN'S NAME (Type) P. P. JOSHI MD				23D. ADDRESS 730 ASHBURTON ST. BALTO-16.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/68		24C. NAME OF CEMETERY or CREMATORY London Mt.	
24D. LOCATION Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 14 1968		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR 444 J. Trachner & Son Balto., Md.		24H. ADDRESS		24I. ADDRESS	

May 10, 1911

Dear Sir,

No.

Wm. A. Lawrence

Wm. A. Lawrence
1011 10th St. N.W.
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11396

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11396

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. MAGGIE DAVIS</i>		2. DATE AND HOUR OF DEATH <i>11-11-68</i> <i>9:45</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>11-04</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>401 Watty Court</i>					
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-1897</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>68-11397</i>		11. BIRTHPLACE (State or foreign country) <i>Charlotte, N. C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>John Ross</i>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>217-18-3031</i>		17. INFORMANT <i>Frances Hinton - 401 Watty Court</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: <i>Basilar artery Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASHD with hardening of arteries and Atrial Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Fever of undetermined origin</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION <i>4-20-1</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>9/22/68</i> 19 to <i>11/11/68</i> 19, that (I) (we) last saw the deceased alive on <i>11/11/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuela Mendes Ribeiro</i>					23B. DATE SIGNED <i>11/12/68</i>
23C. PHYSICIAN'S NAME (Type) <i>MANUELA MENDES RIBEIRO, M.D.</i>			23D. ADDRESS <i>Mercy Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-15-68</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 14 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
ADDRESS <i>802 Madison Ave.</i>					

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Handwritten text, possibly a signature or name, appearing upside down.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11397
T-413		68-11397		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Essie Talbott		2. DATE AND HOUR OF DEATH 11/9/68 9:45 p/m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3603 Windsor Mill Road, 21216		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH 08-12-14	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bowman, Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Garnet		
14. MOTHER'S MAIDEN NAME Rosa Latmer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 218-05-5903		17. INFORMANT Dessie Moore, 3603 Windsor Mill Road		
18. 154.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF RECTUM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. PSEUDOMONAS PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/2 19 68 to 11/9 19 68 , that (I) (we) last saw the deceased alive on 11/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Michael D. Lutz, M.D.		23B. DATE SIGNED 11/9/68		23C. PHYSICIAN'S NAME (Type) MICHAEL D. LUTZ M.D.
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 11-13-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.

RECEIVED OF DEPT.

RECEIVED OF DEPT.

11/11 11/11 11/11

11/11

MICHAEL D. LUTZ MD
MICHAEL D. LUTZ, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11398	
BIRTH NO. 68-11398		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Roberta Brown</u>		2. DATE AND HOUR OF DEATH <u>11/7/68</u> <u>7:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2307 Ivy Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/84</u>	9. AGE (In years last birthday) <u>84</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gloucester, Va</u>	
13. FATHER'S NAME <u>Joseph Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Gardner, Fannie Willis</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-2407516</u>		17. INFORMANT ADDRESS <u>D Fannie B. Lancaster, 2307 Ivy Ave.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Infection of unknown etiology</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24</u> 19 <u>68</u> to <u>Nov. 7</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 7</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barton A. Cohen</u>		23B. PHYSICIAN'S NAME (Type) <u>Barton A. Cohen</u>		23C. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>NOV 14 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
24G. FUNERAL DIRECTOR <u>Charles R. Law</u>		24H. ADDRESS <u>802 Madison Ave.</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11399

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

NORA WILSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐Month Day Year
November 6, 1968

Hour

11:15 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 226 Spring Street (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year
November 6, 1968

Hour

11:15 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 23, 1907

10. AGE (In years
lost birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

226 Spring Street

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

George Monroe, 226 S. Spring Ct.

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 6, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/11/68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

Nov 23, 1907

U.S.A.

Domestic

George Monroe, 226 S. Spring St.

Administrative Commission

Serial 11111111 Mr. Auburn

Baltimore, Maryland

Nov 11 1907 Charles R. Law Box 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11400	
BIRTH NO. 68-11400		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RUTH ANN PRILEAU		2. DATE AND HOUR OF DEATH 11-9-68 1:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ. of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 317 N. CARROLL TOW. AVE. #23	
5. SEX F	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 53 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patterson Peaks		14. MOTHER'S MAIDEN NAME Georgianna Blackman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-26-1199	
17. INFORMANT Edward Prileau		ADDRESS Same	
18. 124X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic carcinoma (B) Carcinoma of the breast (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 18 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 120X II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22-55 19 to 11-9 19 68 , that (I) (we) lost saw the deceased alive on 11-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael G. Hayes, MD		23B. DATE SIGNED 11-9-68	
23C. PHYSICIAN'S NAME (Type) Michael G. Hayes, M.D.		23D. ADDRESS Univ. of Md. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-13-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION Baltimore, MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Robert E. Jackson		ADDRESS 1727 N. ...	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11401 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11401

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM WASHINGTON		2. DATE AND HOUR OF DEATH 11/10/68 10²⁵ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY -		
FULL NAME OF HOSPITAL OR INSTITUTION 90 HOUSE IN THE PINES 5837 BELLAIRE ROAD. BALTIMORE MD. 21206			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 518 Baker St		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1893	9. AGE (In years last birthday) 75 YRS	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN.		10B. KIND OF BUSINESS OR INDUSTRY NAIVE.		11. BIRTHPLACE (State or foreign country) UNKNOWN	
12. CITIZEN OF WHAT COUNTRY? AMERICA			13. FATHER'S NAME UNKNOWN.		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		
16. SOCIAL SECURITY NO. 212-14-3231			17. INFORMANT ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 422.1 II			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF:		2 years
			(C) Atherosclerosis		2 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/25 1967 to 11-10-1968 , that (I) (we) last saw the deceased alive on 10/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Patient of Dr. A. Bradley.					
23A. SIGNATURE Michael J. Dausch M.D. DEGREE			23B. DATE SIGNED 11-10/68		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) A. BRADLEY			23D. ADDRESS MD. DEGREE 4900 BELLAIRE ROAD BALTO. MD 21206		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetry	
24D. LOCATION Baltimore Md		24E. DATE RECEIVED BY HEALTH DEPT. NOV 12 1968			
25A. NAME OF REGISTRAR Robert E. Bradley		25B. NAME OF REGISTRAR Robert E. Bradley		25C. FUNERAL DIRECTOR I Carroll	
25D. ADDRESS Halstead Funeral Home		25E. ADDRESS 1206 W North Ave			

218 Baker St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <i>Bervola Thornton</i>				2. DATE AND HOUR OF DEATH <i>11/7/1968 9:20 P.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>17-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nursing Home</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90</i>				E. STREET AND NUMBER <i>607 Pennsylvania Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Amer. Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/19/1882</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ALA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Frank Dixon</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>212-56-2667</i>		17. INFORMANT <i>Chart</i>		ADDRESS
18. <i>412.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CVA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
(B) <i>Hypertension. Card. vasc. Disease</i> DUE TO, OR AS A CONSEQUENCE OF:				<i>Unknown</i>			
(C) <i>Art. scl. Heart Disease</i>				<i>Unknown</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>443X II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 5</i> 19 <i>68</i> to <i>Nov. 7</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Nov. 6</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. E. Holt</i>				23B. DATE SIGNED <i>11/7/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>E. E. Holt</i>				23D. ADDRESS <i>3715 Liberty Hwy. Ave. Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/15/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 14 1968</i>				25B. NAME OF REGISTRAR <i>John E. Salyers</i>		25C. FUNERAL DIRECTOR <i>T Carroll, Halstead Funeral Home</i>	
						ADDRESS <i>1206 W North Ave</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

STANLEY

F

BALL

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

November 10, 1968

8:45 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Found at 1029 Pennsylvania Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 11, 1968

10:40 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

2/2/27

10. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1029 Pennsylvania Ave

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Cephus Ball

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Viola

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W 2

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

MRs Chester, Cherry Hill

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Fatty Alteration of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/11/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/15/68

24C. NAME OF CEMETERY or CREMATORY

National Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Md

25A. DATE OF BIRTH HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

I Carroll, Halstead Funeral Home

1206 W North Ave

103d Revised 1944

407 14 103d 1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11404 CERTIFICATE OF DEATH

REG. NO. 68-11404

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SALLIE NICHOLAS		November 11, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 70 The Jewish Convalescent Home				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2413 MADISON AVE.	
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1883	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 164-16-5382	
17. INFORMANT				ADDRESS	
				Mds. Frank Butler, 3504 Callaway Ave/	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 133.8 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: general carcinoma		3 mo.	
		(B) Ca. of Colon		4 years.	
		(C)			
133.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct 28 1968 to Nov. 12 1968, that (I) (we) last saw the deceased alive on Nov. 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. A. Silver				23B. DATE SIGNED 11/14/68	
23C. PHYSICIAN'S NAME (Type) A. A. SILVER M.D.				23D. ADDRESS 6210 Park Heights Ave Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/15/68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Charles E. Sadyra		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11405 CERTIFICATE OF DEATH

REG. NO. 68-11405

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH E SELBY		2. DATE AND HOUR OF DEATH 11-12-68 11:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY BALTIMORE CITY		
FULL NAME OF HOSPITAL OR INSTITUTION CNA; 42			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL of Baltimore		
5. SEX M			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Clerk		10B. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME Lawson Selby			14. MOTHER'S MAIDEN NAME MARIA Disney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-7324		17. INFORMANT Mrs Elizabeth L. Davis 2066 Druid PKD	
18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CIRCULATORY & RESPIRATORY DYSFUNCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RUPTURED ABDOMINAL AORTA			(B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC, AORTA		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 457X II					
19A. DATE OF OPERATION 11-11-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Critical		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 11-11-68 19 to 11-12-68 19, that (I) (we) last saw the deceased alive on 11-12-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Acipon				23B. DATE SIGNED 11-12-68	
23C. PHYSICIAN'S NAME (Type) JOHN CONCEPTION				23D. ADDRESS 40 SINTA HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-15-68		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem	
24D. LOCATION (City, town, or county) (State) Pikesville Balto Co Md		25A. DATE RECEIVED BY HEALTH DEPT. NOV 14 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Burger Funeral Home Balto Md			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11406 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11406

CERTIFICATE OF DEATH

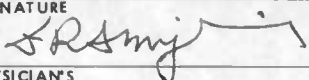
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN L. DAWSON		Nov. 9, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
003622 Greenmount Ave		MARYLAND		C. CITY OR TOWN	
		BALTIMORE		INSIDE CITY LIMITS?	
		3622 GREENMOUNT AVE.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 1, 1886	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired New York Police				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
John J. Dawson		Theresa Mc Gah		16. SOCIAL SECURITY NO.	
		17. INFORMANT		ADDRESS	
		Mr. Wm. F. Dawson		3622 Greenmount Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Coronary Occlusion Sudden	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerotic Cardio-	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) REMAINING VASCULAR DISEASE 10 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 1966 to 9 November 1968, that (I) (we) last saw the deceased alive on 29 October 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Charles F. O'Donnell		11/10/68		Charles F. O'Donnell MD	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
7501 York Rd. Towson		H. W. Mears & Son		805 N. Calvert St	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	24E. STATE	
Burial	11/13/68	New Cathedral	Baltimore, Md.		
25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			
NOV 14 1968	Robert E. Sullivan	H. W. Mears & Son			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11407 CERTIFICATE OF DEATH

REG. NO. 68-11407

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. JESSAMINE M. MANFUSO Mrs. Jessie Manfuso		2. DATE AND HOUR OF DEATH 11/9/68 1:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland - B. COUNTY Baltimore City	
FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/22/84		9. AGE (In years last birthday) 83		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Neil Miccio		14. MOTHER'S MAIDEN NAME Marie Paturza Miccio			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Admission Note Josephine Shehan - 108 Taylor St. Baltimore, Md. 8902 CANTERBURY RD	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardio-Vascular Collapse ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome, Associated with Senile Brain Disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 - 11 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/21/61 19 to 11/9/68 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/9/68 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 11/9/68	
23C. PHYSICIAN'S NAME (Type) Raphael Nigrin, M.D.				23D. ADDRESS 6400 Wabash Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/12/68		NEW CATHEDRAL	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR H.W. MEARS & SON	
				ADDRESS 805 N. CALVERT ST.	

A-216

68-11408 BALTIMORE CITY HEALTH DEPARTMENT

68-11408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH ^{or} Lizzie ASHFORD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 11, 1968 Hour 9:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 11, 1968 Hour 9:20 P.M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-1-1912		10. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Winnsgboro, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY At home	
15. MOTHER'S MAIDEN NAME Mary White		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 208-03-0610		18. INFORMANT Baron Ashford	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II	
23A. DATE OF OPERATION 0		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 11/11/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-19-68	
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Pk.		24D. LOCATION (City, town, or county) (State) Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. J. J. J.	
25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11409

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11409

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHAMBERS JAMES ARTHUR		2. DATE AND HOUR OF DEATH 11/7/68 7 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSP 44				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 2234 PRENTISS PL.	
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/22	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAULER		10B. KIND OF BUSINESS OR INDUSTRY MOVING CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Robert Chambers		14. MOTHER'S MAIDEN NAME Pearl Simms	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. 2		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. AVON CHAMBERS ADDRESS SAME	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 493X I Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7d 2d	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 10/30/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATION ASST		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 68 to 11/7 19 68 , that (I) (we) last saw the deceased alive on 11/7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown DEGREE				23B. DATE SIGNED 11/7/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNION MEMORIAL HOSPITAL DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-12-68		24C. NAME of CEMETERY or CREMATORY National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Randolph J. Collick ADDRESS 2431 E. Oliver St.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11410 CERTIFICATE OF DEATH

REG. NO.

68-11410

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NELSON, George Edward

2. DATE AND HOUR OF DEATH

November 10, 1968

1:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)
Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2402 E. Madison Street

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-9-97

9. AGE (In years
last birthday)

71

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter & Decorator

10B. KIND OF BUSINESS OR INDUSTRY

Painting

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George E. Nelson

14. MOTHER'S MAIDEN NAME

~~Christina Kiga niester~~ ANNA KUECHENMEISTER15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

8-27-18 to 12-5-18

16. SOCIAL
SECURITY NO.

214-01-96-75

17. INFORMANT

Records

ADDRESS

21218

VA Hosp. 3900 Loch Raven Blvd. Balto., Md.

18.

485 X-1-62.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Broncho-pneumonia w/Respiratory Arrest 4 Days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

491X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Carcinoma of Right Lung

6 Months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from September 12 19 68 to November 10 19 68,
that ☒ (we) last saw the deceased alive on November 10 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

ELLIS L. JONES

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-11-68

23D. ADDRESS

3900 Loch Raven Blvd.
Baltimore, Md. 21218

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-13-68

24C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL CEM.

24D. LOCATION

(City, town, or county)

BALTO., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Hartley Miller - 2334 Jefferson St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

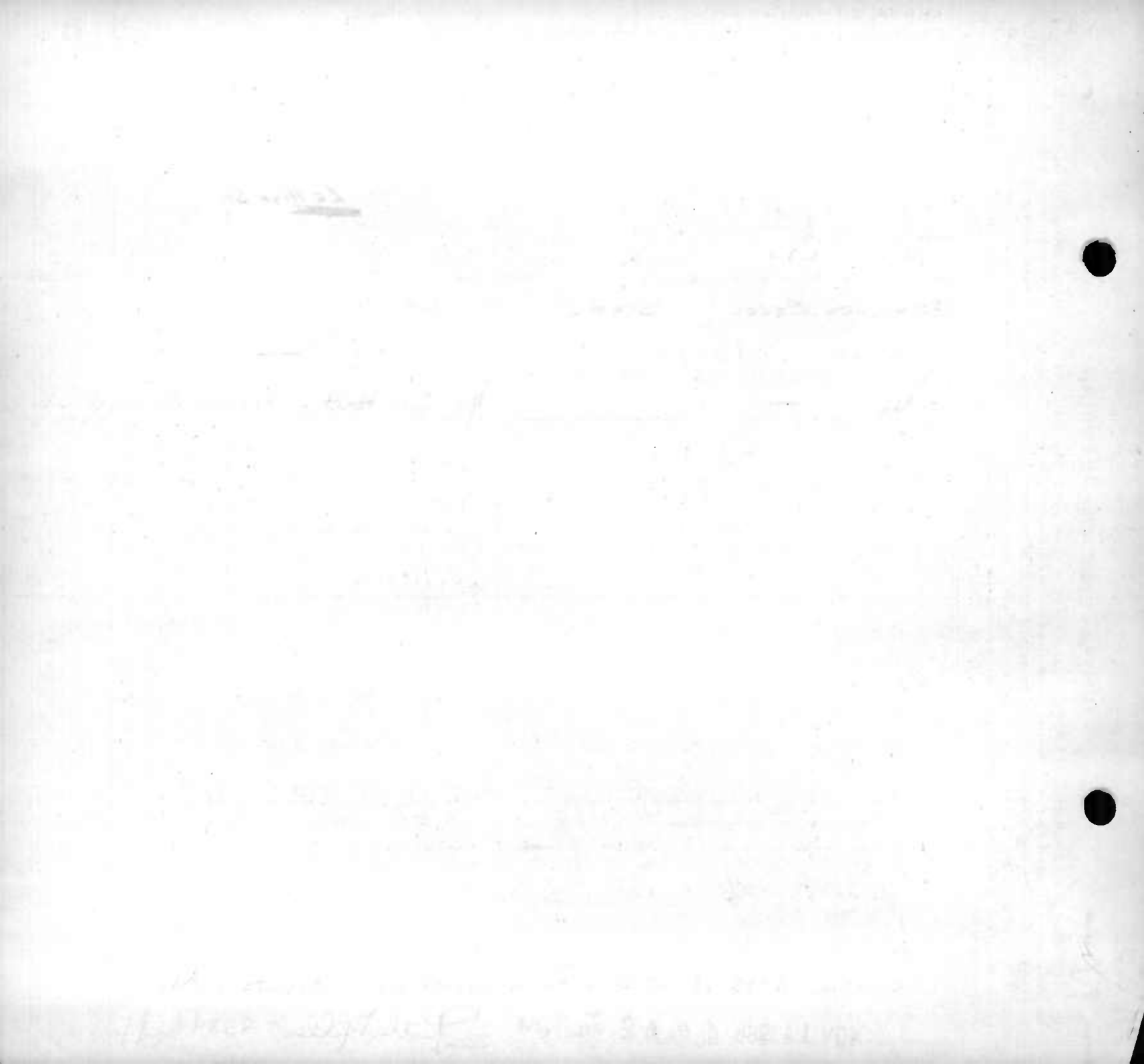
68-11411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11411

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Stanley Dudziak (DUDZIACK)</u>		2. DATE AND HOUR OF DEATH <u>11/9/68</u> <u>11:30</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26-07</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>308 S. HIGH ST.</u>		<u>21224</u>
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/24/94</u>	9. AGE (In years lost birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BETHLEHEM STEEL</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Andrew Dudziak</u>		
14. MOTHER'S MAIDEN NAME <u>Mary</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Lela Hart - 310 S. Schick St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>313.01</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>523.0 II</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2° Pseudomonas Pneumonia</u> <u>2° Chronic obstructive Puldis.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Silicosis</u> (C) _____		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>68</u> to <u>11/9</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John B. Hardman M.D.</u>			23B. DATE SIGNED <u>11/9/68</u>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>			24B. DATE <u>11-13-68</u>		
24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CREMATORY</u>			24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 14 1968</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		
25C. FUNERAL DIRECTOR <u>Fortley Miller</u>			25D. ADDRESS <u>2334 Jefferson St.</u>		



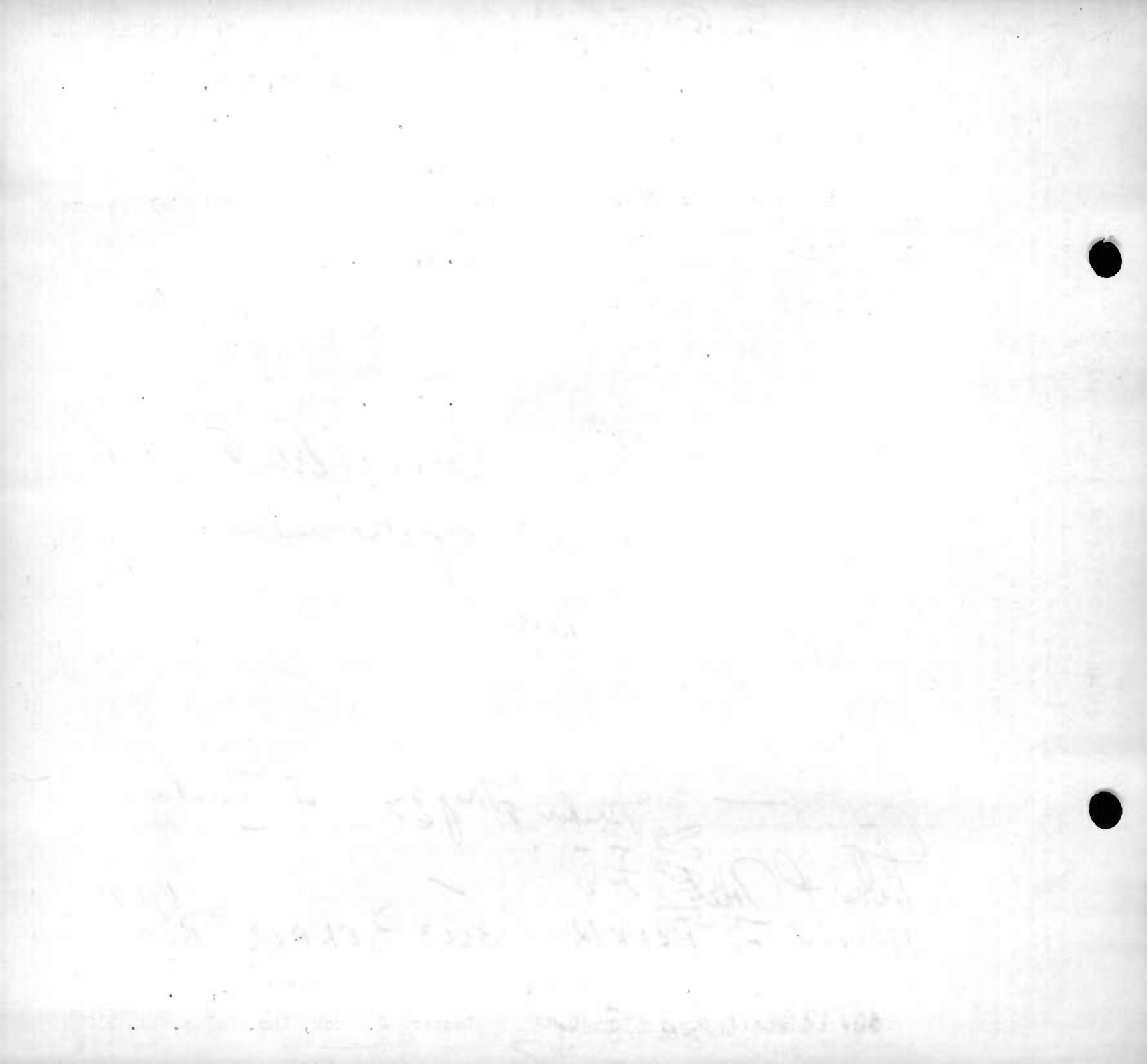
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11412 CERTIFICATE OF DEATH

REG. NO. 68-11412

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES W. ROSIER		November 13, 1968. 11:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 Union Memorial Hospital DOA				A. STATE Md. B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5500 Plainfield Avenue	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1914.	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent--Sales		10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles F. Rosier	
14. MOTHER'S MAIDEN NAME Carrie Fauth				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Anna M. Rosier	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4-12-4 I CORONARY ARTERIO SCLEROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>May 20 1968</u> to <u>February 13 1968</u> , that (I) (we) last saw the deceased alive on <u>February 13 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE Melvin F. Pokrka, M.D. 23B. DATE SIGNED 11/14/68 23C. PHYSICIAN'S NAME (Type) MELVIN F. POKRKA 23D. ADDRESS 3603 BELAIR ROAD. BALTO. MD. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/16/68. 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery 24D. LOCATION Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968 25B. NAME OF REGISTRAR Robert E. Sullivan 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-6221

68-11413 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11413

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ferguson, Dale J.

2. DATE AND HOUR OF DEATH

13 November 1968 11:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

1930 JASMINE ROAD

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-8-47

9. AGE (In years last birthday)

21

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY

Gen Auto Parts Co

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

S.

WALTER PIPINO, Jr.

14. MOTHER'S MAIDEN NAME

MILDRED R. Cantwell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Louis E. Ferguson, Mr.-Same

18. 433.71

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Thrombosis +
INTRACEREBRAL
hemorrhage

(B) _____

DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 11 November 1968 to 13 November 1968, that (I) (~~was~~) last saw the deceased alive on 13 November 1968 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~did~~) (~~did not~~) view the body after death.

23A. SIGNATURE

L. J. Buckels M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

13 November 1968

23C. PHYSICIAN'S NAME (Type)

Larry J. BUCKELS M.D.

DEGREE

23D. ADDRESS

Johns Hopkins Hospital, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/18/68

24C. NAME of CEMETERY or CREMATORY

Most Holy Redeemer Cem. Baltimore, Md.

24D. LOCATION

(City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

25B. NAME OF REGISTRAR

Philip E. J. J. J.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md. 21214

ADDRESS

25 November 1942

Green

Cerebral Thrombosis +
intercerebral
hemorrhage

NO

YES

NO

14 November 42

14 November 42

John H. Hays
M.D.
X

L. J. Buckle M.D.
Lary J. Buckers M.D.

FUNERAL DIRECTOR: IMPORTANT

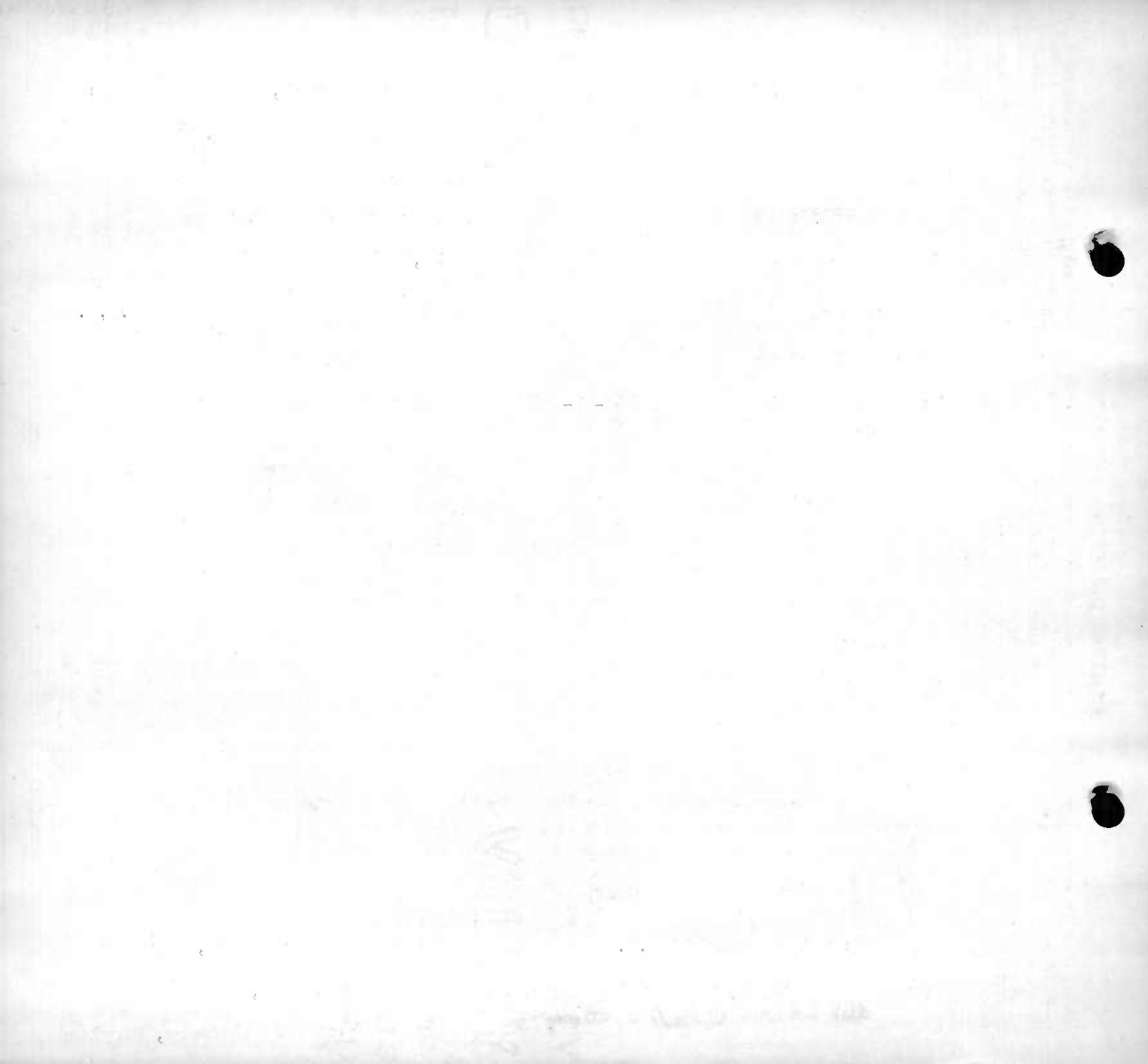
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11414 CERTIFICATE OF DEATH

REG. NO.

68-11414

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Harry B Winkelman		2. DATE AND HOUR OF DEATH November 13, 1968 9:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 8. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4206 ANNTANA AVE		C. CITY OR TOWN Baltimore E. STREET AND NUMBER 4206 ANNTANA AVE	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1895	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry R Winkelman		14. MOTHER'S MAIDEN NAME Catherine Schlund		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 218-42-8075		17. INFORMANT Mrs Thelma Winkleman ADDRESS Same	
18. 430.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage around Circle of Willis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Semile		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage around Circle of Willis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 330X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Aug 8 1939 to 11-13-68 that (I) (we) last saw the deceased alive on 11-13-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.					
23A. SIGNATURE M. J. Grossfeld M.D.		23B. DATE SIGNED 11-13-68		23C. PHYSICIAN'S NAME (Type) Michael J Grossfeld M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk	
25A. DATE RECEIVED NOV 14 1968		25B. NAME OF REGISTRAR Leonard J. Ruck Inc		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS 5402 Belair Rd Baltimore, Maryland		24F. ADDRESS Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

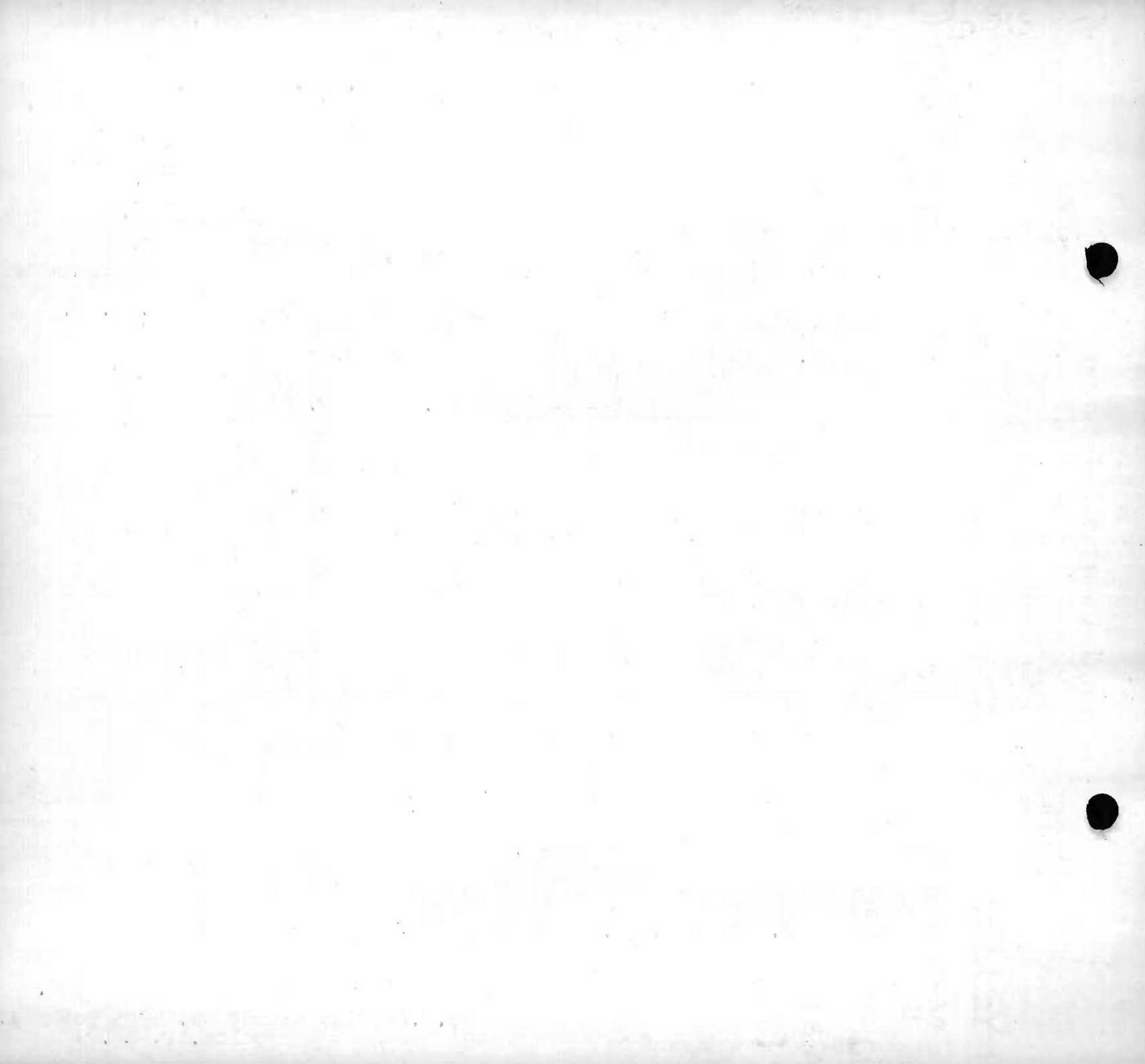
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11415 CERTIFICATE OF DEATH

REG. NO.

68-11415

BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. Teresa Goodwin		2. DATE AND HOUR OF DEATH Nov. 13, 1968 11:05 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 405 Southway		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1881	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William H. Wills		14. MOTHER'S MAIDEN NAME Teresa Hook	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-2596		17. INFORMANT Mrs. James H. Ellison	
18. 772-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiac - vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20+ yrs.	
(B) Arterial hypertension DUE TO, OR AS A CONSEQUENCE OF: 25 yrs.		(C) _____		_____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 10 1947 to Nov 13 1968 , that (I) (we) last saw the deceased alive on Nov 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer DEGREE				23B. DATE SIGNED Nov 14, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer		23D. ADDRESS 6100 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/1968		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd.		25E. (City, town, or county) Balto.		25F. (State) Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11416 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11416

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOIS HOLT TATE		2. DATE AND HOUR OF DEATH 14 NOV. 1968 1:45 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Lutherville
					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER College Manor		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/05/82	9. AGE (in years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DR. William Edwin Holt			14. MOTHER'S MAIDEN NAME DR. Amelia Holt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNR No.		16. SOCIAL SECURITY NO. 244-724293	17. INFORMANT Harriet Bryant P. D., Charlotte, N.C. (Anna Waters, private nurse.)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-78X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD			CAUSE OF DEATH (A) IMMEDIATE CAUSE Abdominal infection DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (b) (this hospital) attended the deceased from Nov 2 1968 to Nov 14 1968 , that (b) (we) last saw the deceased alive on Nov 13 1968 and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Brian Block			23B. DATE SIGNED 14 Nov 68		23C. PHYSICIAN'S NAME (Type) BRIAN BLOCK
			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Elmwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Charlotte, N. C.	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Balto. 12, Md.	

Page 1

UNION MEMBERSHIP REPORT

College Station

10/27/28

North Carolina

One

and others

Abdominal

AS CVD

Nov 18

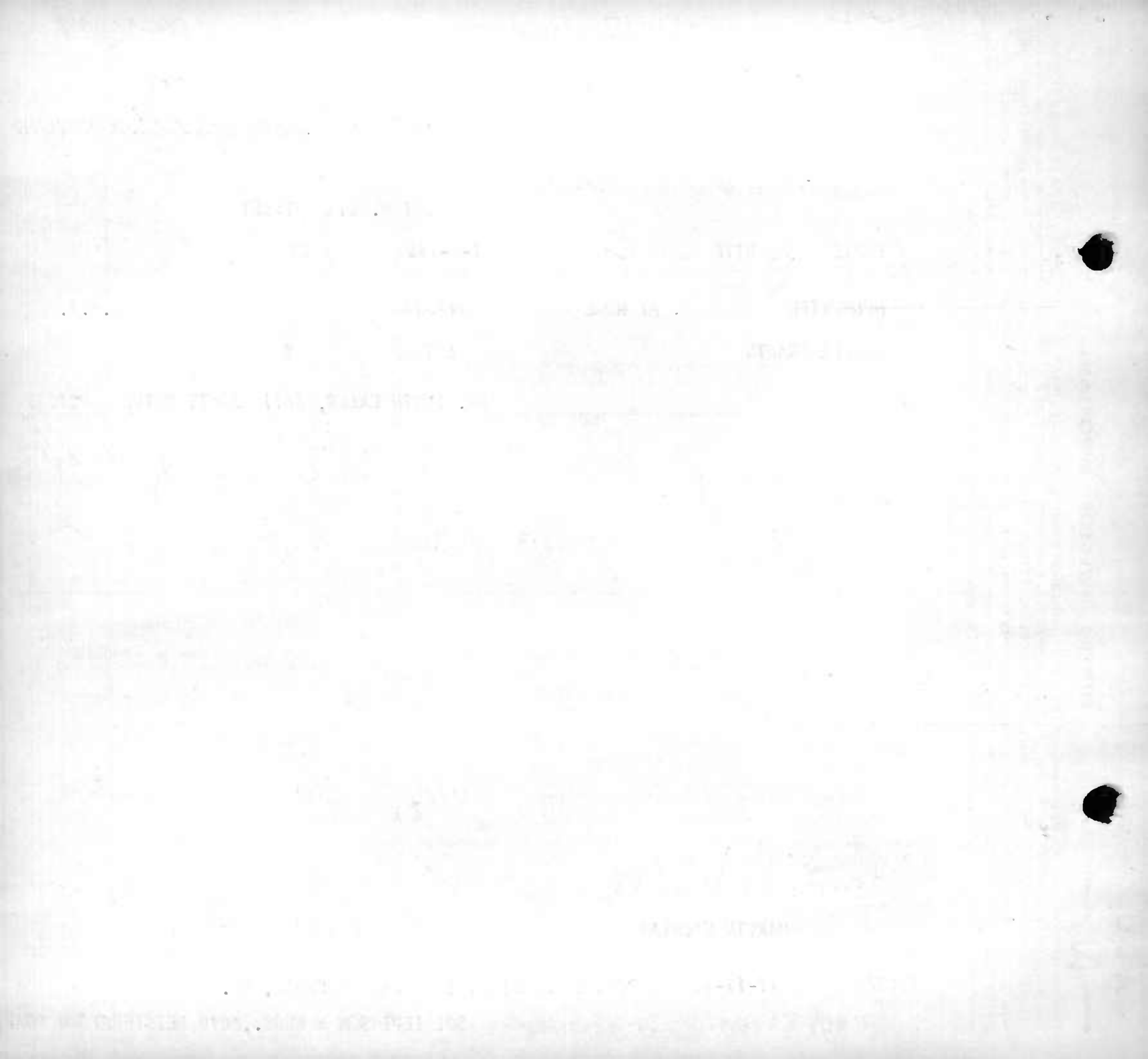
John

Brain Block

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-246		68-11417		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11417	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Exler, Mollie</i>			
2. DATE AND HOUR OF DEATH <i>11/10/68 2:40 PM</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Balto.</i>				A. STATE <i>MD</i> B. COUNTY <i>Harford</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>501 W. 27th STREET</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-5-1889</i>	9. AGE (In years lost birthday) <i>79</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SAMUEL FRADIN</i>				14. MOTHER'S MAIDEN NAME <i>ESTHER ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MR. IRVIN EXLER, 6611 MAROTT DRIVE #21207</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>260X I</i>		CAUSE OF DEATH <i>① Diabetic gangrene of lower extremity</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-2 days</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>260X II</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>② Diabetes mellitus</i>					
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>③ Atherosclerotic heart disease</i>					
		(C) _____					
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <i>0 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/10</i> 19 <i>68</i> to <i>11/10</i> 19 <i>68</i> and that (I) (we) lost saw the deceased alive on <i>11/10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Marvin Nachlas</i>				23B. DATE SIGNED <i>11/10/68</i>		23C. PHYSICIAN'S NAME (Type) <i>MARVIN NACHLAS</i>	
23D. ADDRESS <i>2 E. 2nd St</i>		23E. ADDRESS <i>2 E. 2nd St</i>		23F. ADDRESS <i>2 E. 2nd St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-11-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>BOBROISKER BENEFICIAL CIRCLE</i>		24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 14 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS.</i>		25D. ADDRESS <i>6010 REISTERSTOWN ROAD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11418
7-6000		68-11418		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Turow, Herman			2. DATE AND HOUR OF DEATH 2:55 PM 11-11-68		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital 42			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY RETAIL		8. DATE OF BIRTH 9-18-03
13. FATHER'S NAME MEYER TUROW			14. MOTHER'S MAIDEN NAME ETHEL ?		9. AGE (In years lost birthday) 65
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A
17. INFORMANT MRS. DOROTHY TUROW, FALLSTAFF MANOR APTS. APT. E, 3017 ROMARIC COURT #21209			ADDRESS		
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) CVA, coronary disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION 331X II			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from 10-26-68 to 11-11-68 , that (I) (we) last saw the deceased alive on 11-11-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23A. SIGNATURE E. A. A. A. A.			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS SINAI HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11-13-68		
24C. NAME OF CEMETERY OR CREMATORY NEW HAR SINAI			24D. LOCATION (City, town, or county) (State) OWINGS MILLS, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968			25B. NAME OF REGISTRAR Robert E. Farber		
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			25D. ADDRESS		



68-11419

BALTIMORE CITY HEALTH DEPARTMENT

68-11419

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN JENKINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 5, 1968 Hour 1:30 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1316 N. Montford Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 5, 1968 Hour 6:30 A.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 16, 1928 10. AGE (In years last birthday) 40 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1316 N. Montford Avenue	
11. BIRTHPLACE (State or foreign country) Balto, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gilbert Jenkins		14. MOTHER'S MAIDEN NAME Alfina	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabman		14B. KIND OF BUSINESS OR INDUSTRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence Jenkins		ADDRESS	
19. CAUSE OF DEATH 343.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 343.91 II		DEATH DURING EPILEPTIC SEIZURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner J. Spitz M.D. EXAMINER'S NAME (Type) Werner J. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/5/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 9/68	
24C. NAME OF CEMETERY or CREMATORY St. Ambrose Cem		24D. LOCATION (City, town, or county) (State) Wheatfield Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Frank T. Election		ADDRESS 1129 N. Carberry	



March 18 1881

~~March 18 1881~~

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		68-11420		BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-11420	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DAVIS, MATTIE			
2. DATE AND HOUR OF DEATH 11/11/68 12:45 P M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601N. BROADWAY BALTIMORE, MARYLAND 21205				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 1435 N. GAY STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/98 80	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) V.A.			
13. FATHER'S NAME BEVERLY JEFFRIES				14. MOTHER'S MAIDEN NAME ROSE HEWS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT General Miller 319 E. Montana St. Pa	
18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage x2 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probable aneurysm				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION 330X II				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (1) (his hospital) attended the deceased from 11/8/68 to 11/11/68 , that (1) (we) last saw the deceased alive on 11/11/68 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 11/11/68			
23A. SIGNATURE Marc Lipman MD				23D. ADDRESS Johns Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/16/68			
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.				24D. LOCATION (City, town, or county) (State) Wheatport Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968				25B. NAME OF REGISTRAR Robert E. Johnson			
25C. FUNERAL DIRECTOR Milton E. Elukh				25D. ADDRESS 1129 N. Calhoun			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 0-435		68-11421		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-11421	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) George Gladden			
2. DATE AND HOUR OF DEATH 7:00 AM 11/10/68 M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE, MD 21205				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 1616 N. BOND STREET							
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-17-95	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 7		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GEORGE Gladden				14. MOTHER'S MAIDEN NAME SARAH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 216-09-3265		17. INFORMANT Lucius		ADDRESS	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Massive GI Hemorrhage 48 hours			
ANTECEDENT CAUSES				(B) DUE TO ulcer disease & GI Surgery 3 weeks			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Stress of generalized sepsis 4 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe Parkinsonism							
19A. DATE OF OPERATION 2-10-5-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CLOSURE OF PERFORATED ULCER		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9/22 19 68 to 11/11/ 19 68, that (1) (we) last saw the deceased alive on 11/11/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marc Lippman M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/11/68	
23C. PHYSICIAN'S NAME (Type) Marc Lippman M.D.				23D. ADDRESS Johns Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/14/68		24C. NAME OF CEMETERY OR CREMATORY Bold Natl. Cem		24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Joseph P. [Signature]		ADDRESS 1129 N. [Signature]	

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68-11422 BALTIMORE CITY HEALTH DEPARTMENT

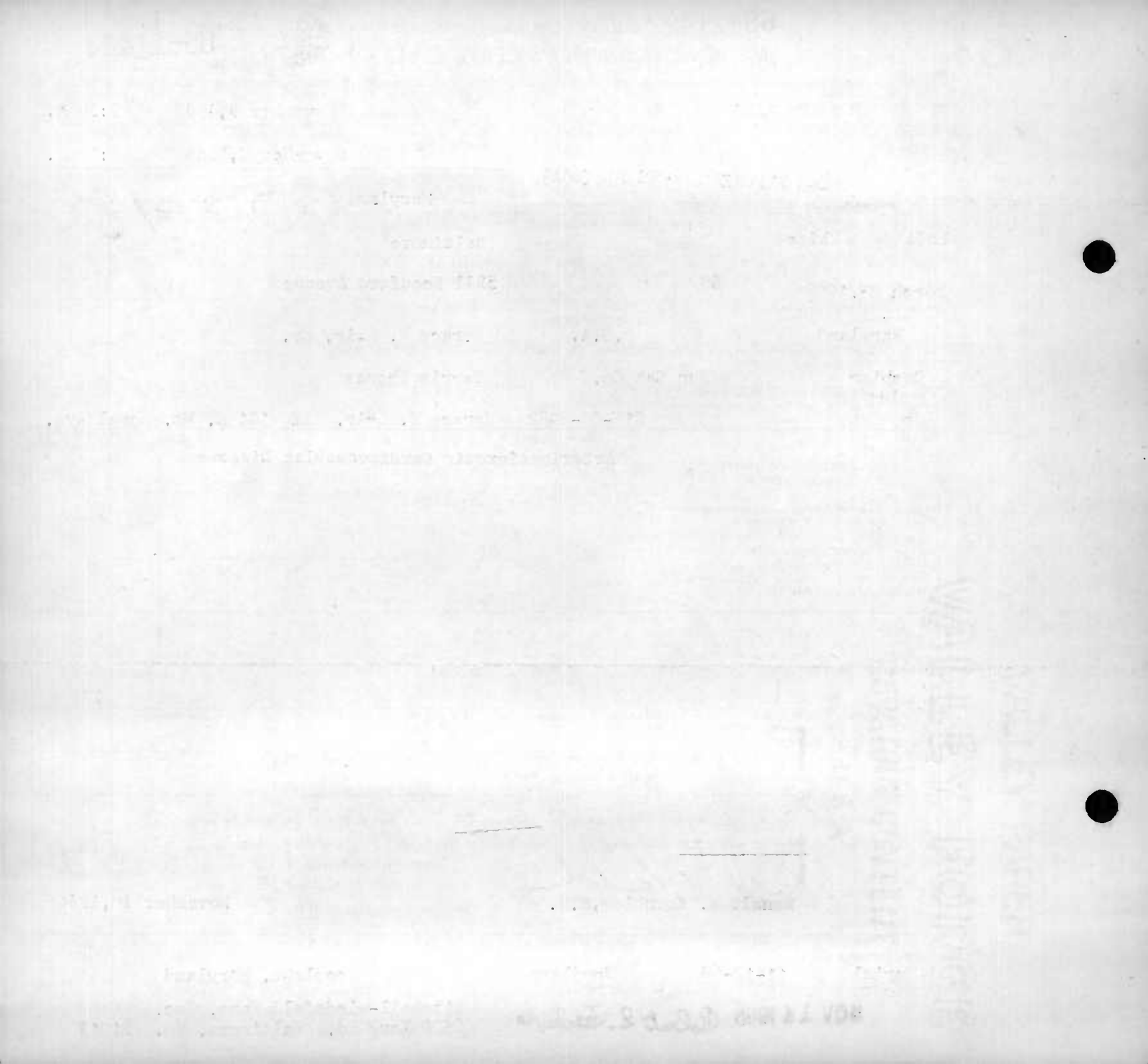
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11422

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HORACE LAIR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 9, 1968 Hour 9:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 9, 1968 Hour 9:30 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 25, 1908		10. AGE (In years lost birthday) 60 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		14B. KIND OF BUSINESS OR INDUSTRY Sun Cab Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-03-8482	
18. INFORMANT Horace W. Lair, III		ADDRESS 101 E. Mt. Royal Ave.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 10, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-12-68	
24C. NAME of CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Baltimore, Md. 21212	



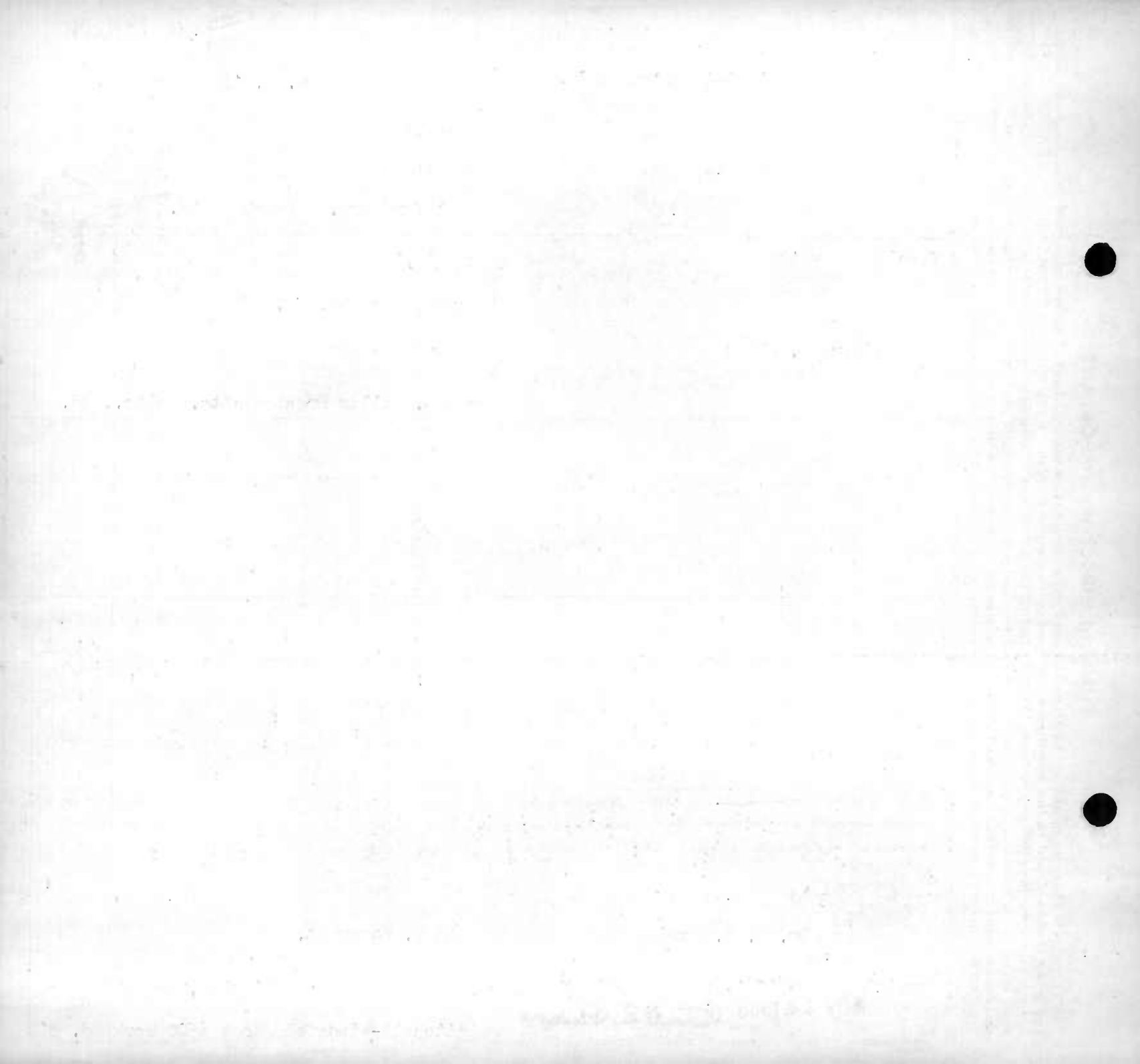
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11423 CERTIFICATE OF DEATH

REG. NO. 68-11423

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Virginia Allen Dallam		2. DATE AND HOUR OF DEATH Nov. 7, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 Preston Apts (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 11-01			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER Guilford Ave. & Preston Sts.			
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1898		9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward M. Allen				14. MOTHER'S MAIDEN NAME Grace Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John W. Dallam Preston Apts. Balto., Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 441.2 I 457X II							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral aneurysm Not known (B) rupture aneurysm DUE TO, OR AS A CONSEQUENCE OF: 5 minutes (C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 4 1946 to November 7 1968 , that (I) (we) lost saw the deceased alive on November 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. H. Boyd DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov. 11 1968	
23C. PHYSICIAN'S NAME (Type) Dr. C. H. Boyd				23D. ADDRESS 24 E. Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9/11/1968		24C. NAME OF CEMETERY or CREMATORY Darlington		24D. LOCATION (City, town, or county) (State) Darlington, Maryland	
25A. DATE RECEIVED NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. #12			



FUNERAL DIRECTOR: IMPORTANT

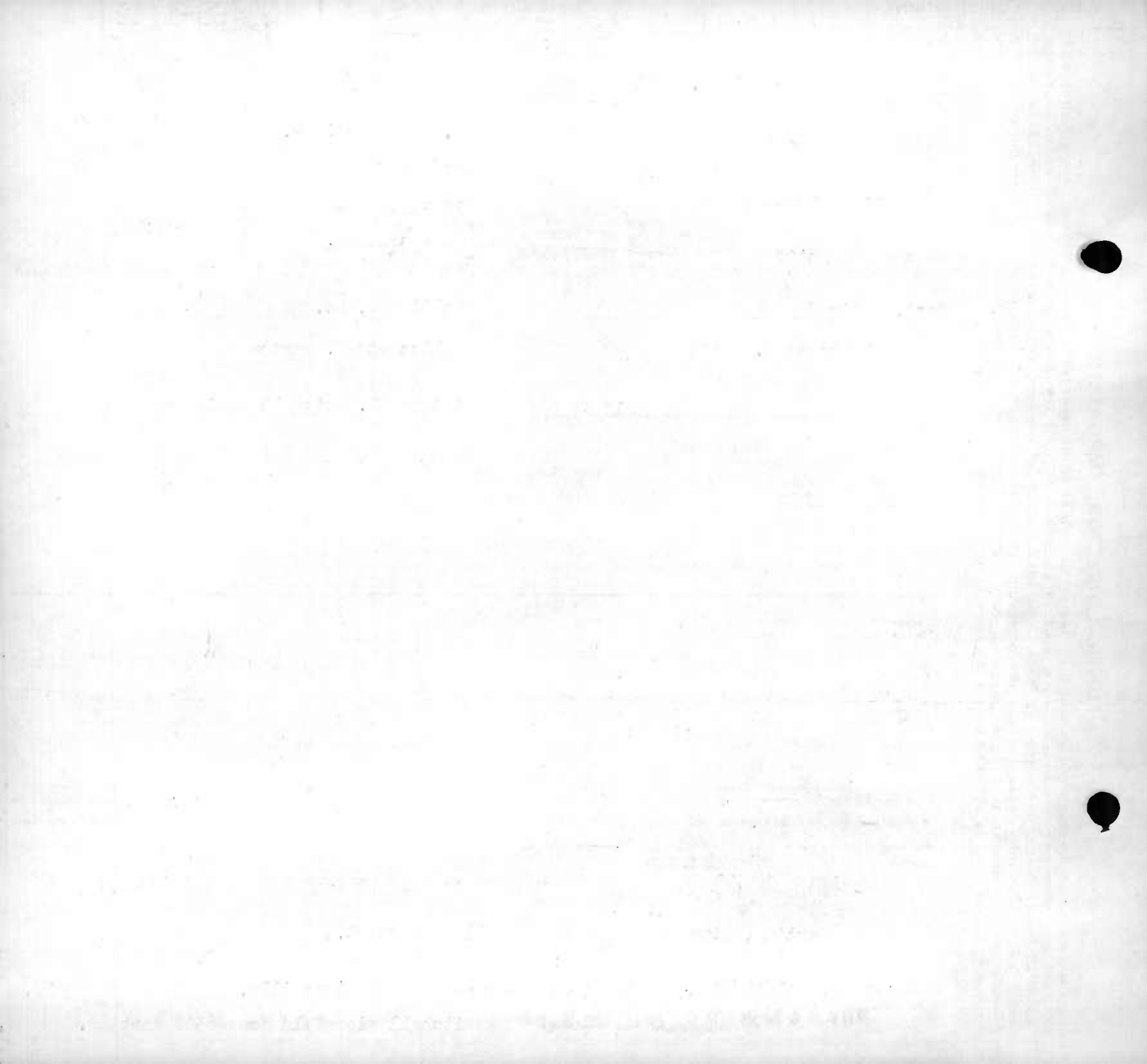
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11424

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jessie V. Smith		11/8/1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home 115 Melrose Ave		A. STATE Md. B. COUNTY Baltimore		53-00	
C. CITY OR TOWN Woodbrook		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 13 McKim Ave					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1886	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect. Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Thomas H. Smith		14. MOTHER'S MAIDEN NAME Elizabeth J. Barton		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 03 0698		17. INFORMANT Winthrop W. Smith 13 McKim Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior Septal Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from May 16 1952 to 11/8/68 19 that (I) last saw the deceased alive on Nov 5 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Martin L Singewald M.D.		23B. DATE SIGNED 11/11/68		23C. PHYSICIAN'S NAME (Type) Martin L Singewald	
23D. ADDRESS 11 E Chase St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/11/68		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE RECD BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.	



68-11425

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11425

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN DORSEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> November 11, 1968 6:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		3. DATE PRONOUNCED DEAD November 11, 1968 6:35 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Leonardtown	
9. DATE OF BIRTH Aug. 5, 1912		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-30-1180	
18. INFORMANT CARRY DORSEY MORGANZA, MARYLAND		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION November 10, 1968		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Laparotomy	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Grave Yard Road, Leonardtown, Maryland		22D. TIME OF INJURY (Approx.) 11/10/68 1:55 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. driver of auto - hit another car head-on.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11/12/68			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV. 15, 1968	
24C. NAME OF CEMETERY or CREMATORY St. JOSEPHS		24D. LOCATION (City, town, or county) (State) MORGANZA, ST. MARY'S, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25D. ADDRESS LEONARDTOWN, MARYLAND	

YINCHU YINCHU

11/10/10
11/10/10

FUNERAL DIRECTOR: IMPORTANT

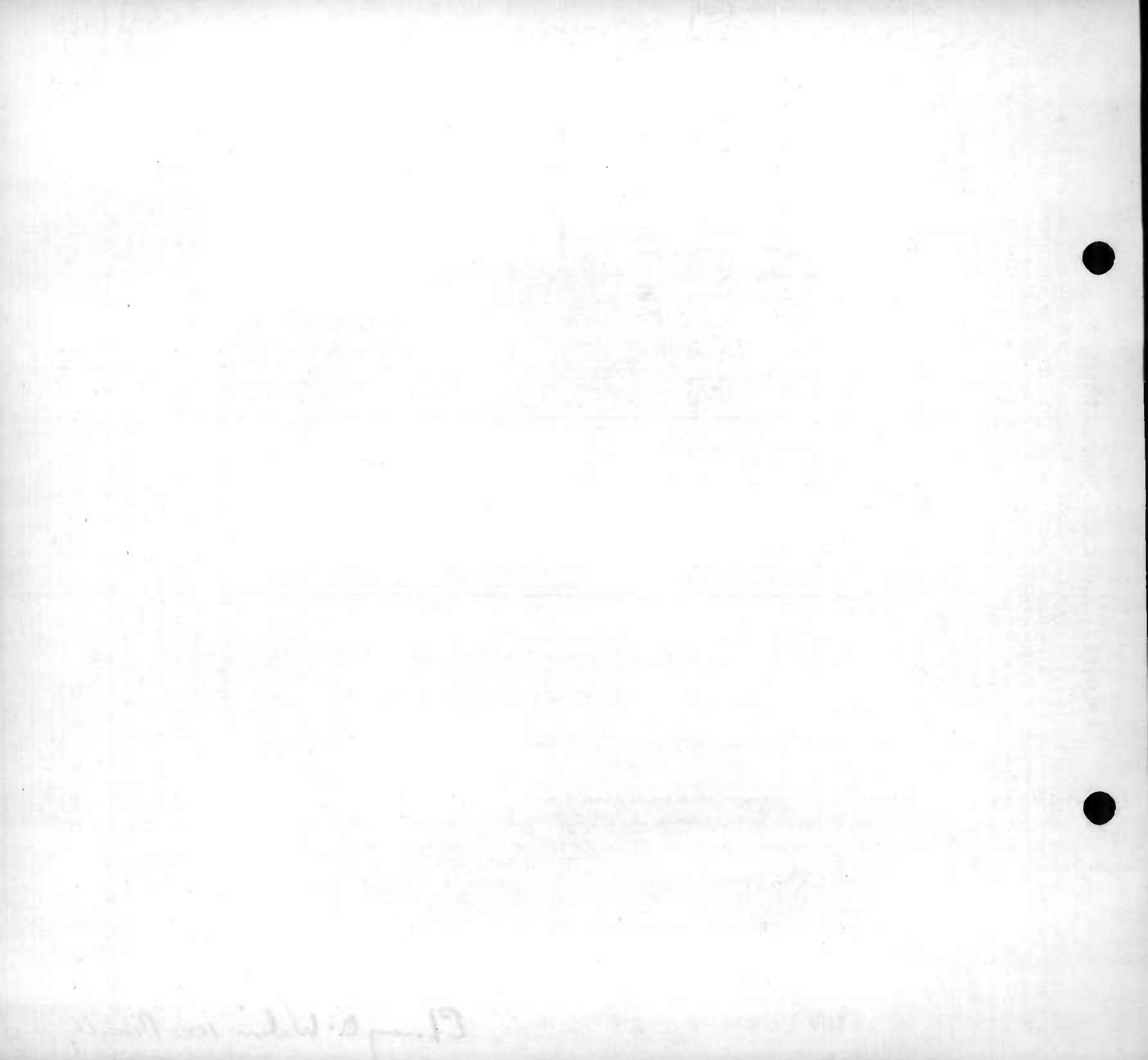
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11426 CERTIFICATE OF DEATH

REG. NO.

68-11426

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STEWART ERNEST N. STEWART		2. DATE AND HOUR OF DEATH NOV 12, 68 6:44 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL 100 N. CALHOUN ST. BALTO, MD 21223			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE		
5. SEX M 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER			11. BIRTHPLACE (State or foreign country) WEST INDIES		12. CITIZEN OF WHAT COUNTRY? U.S.A.?
13. FATHER'S NAME HENRY STEWART			14. MOTHER'S MAIDEN NAME IMOGENE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. 21903 3513		17. INFORMANT ADDRESS SUNAN JONGKASEMSIR MD, F.S.H.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 5-20-68 II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Valvulus of small intestine (B) DUE TO, OR AS A CONSEQUENCE OF: intestinal infarction (C) _____		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-09-1968 to 11-12-1968 , that (I) (we) last saw the deceased alive on NOV. 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sunan Jongkasemsiri				23B. DATE SIGNED NOV 12, 68	
23C. PHYSICIAN'S NAME (Type) SUNAN JONGKASEMSIR				23D. ADDRESS FRANKLIN SQUARE HOSP. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-16-68		24C. NAME OF CEMETERY or CREMATORY MT. Calvary C.	
24D. LOCATION (City, town, or county) Brooklyn		24E. (State) Ind.			
25A. DATE REC'D BY HEALTH DEPT. NOV 14 1968		25B. NAME OF REGISTRAR R. A. E. Jones		25C. FUNERAL DIRECTOR ADDRESS Elmer O. Wilson 1000 Broadway Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11427

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LUCILLE DEAN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

13

68

12:15a M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

2018 E. Eager St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 13, 1968

12:15 a.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

Female

7. RACE

Colored

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct 10 - 1912

10. AGE (In years
last birthday)

58 56

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2018 E. Eager St.

11. BIRTHPLACE (State or foreign country)

Clinton, S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Brooks Opomer

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Brenda Dean Same

ADDRESS

19. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Edward F. Wilson, M.D.

November 13, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-16-68

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION

Balto Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

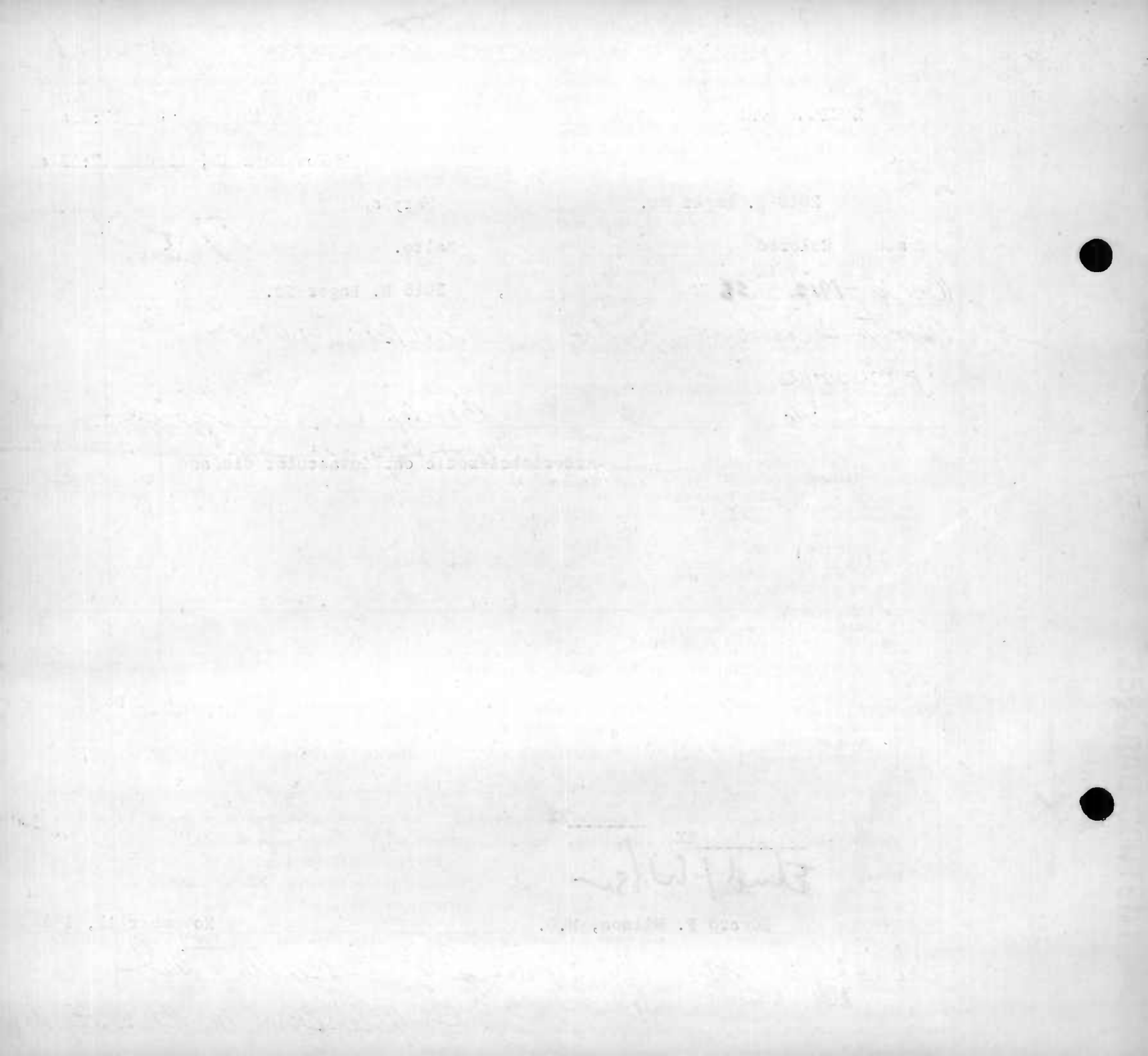
25B. NAME OF REGISTRAR

Robert E. Seaborn

25C. FUNERAL DIRECTOR

Eloy Wilson 1000 Brantly Rd

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11428

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LYMAN

COOK

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 10, 1968

3:35 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 10, 1968

3:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

August 1, 1932

10. AGE (In years
last birthday)

36

Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1408 Fairmount Ave.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war and dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Gunshot Wound of Neck and Chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

service station

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?1204 E. Preston St. (Midway Service
Station)22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11/10/68 3:30 P.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. shot during attempted holdup

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/11/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-18-68

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cat

24D. LOCATION

(City, town, or county)

(State)

A.A. County Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 14 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Choy Wilson

ADDRESS

1000 Brumby Ave

THE UNIVERSITY OF CHICAGO

WALTER D. HOWARD

JOHN H. HOWARD

WALTER D. HOWARD

1911

WALTER D. HOWARD

68-11429

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11429

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

McKINLEY GRAY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

13

68

12:05p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1105 Low St. D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 13, 1968

12:05 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

March 12 1905

63

E. STREET AND NUMBER

1105 Low St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Gray

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elizabeth Kelley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

no

17. SOCIAL
SECURITY NO.

313-09-0361

18. INFORMANT

E. Gray

ADDRESS

Lanier

19. E8871X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Fracture of cervical
vertebrae (neck)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

E9040 II

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Home

1105 Low St

5-02

22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Fell

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Burial 11-16-68

Mt Calvary Ch

A A County Md

NOV 14 1968

Robert E. Taylor

Edward Wilson 1000 Brantford

Partners of Capital
Paper (and)

WALTER
JAMES
JAMES
JAMES

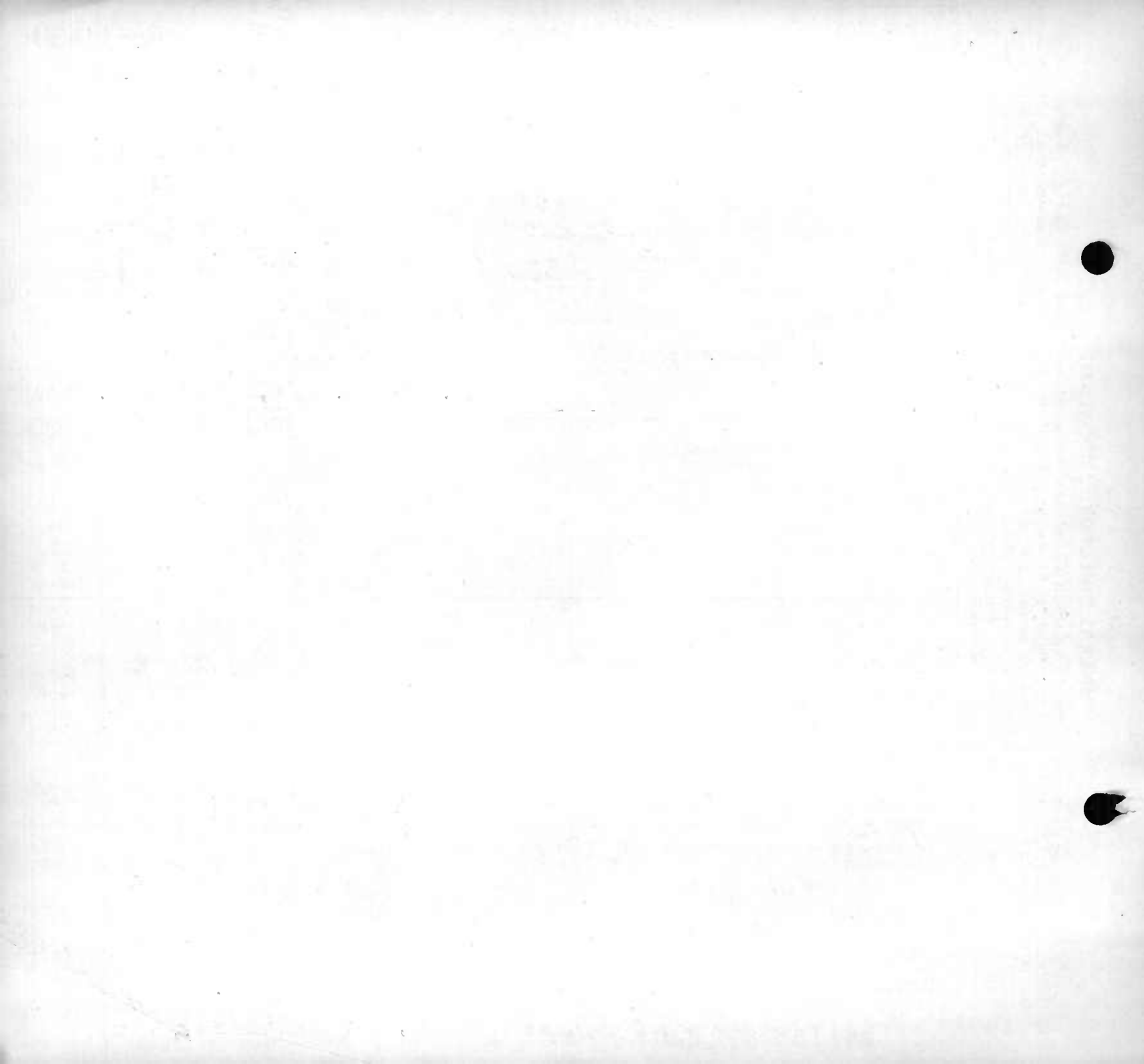
FOR
JAMES
JAMES
JAMES

NOV 14 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-100		68-11430		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11430	
1. NAME OF DECEASED (Type or Print) SHIPP, MR. HOWARD M.				2. DATE AND HOUR OF DEATH 11/14/68 3:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-04 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4400 ROKEY ROAD			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/06	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN A. SHIPP				14. MOTHER'S MAIDEN NAME MORRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-09-0409		17. INFORMANT Mrs. Howard M. Shipp		ADDRESS 4400 Rokeby Rd. 21229	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory failure (B) DUE TO, OR AS A CONSEQUENCE OF: a wt. B12 def. (C) pulmonary embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-14-68 3:20 AM long time	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-2-68 to 11-14-68 , that (I) (we) last saw the deceased alive on 11-14-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Johnny T. Kap M.D.				23B. DATE SIGNED 11-14-68			
23C. PHYSICIAN'S NAME (Type) JOHNNY T. KAP M.D.				23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Edmondson		25C. FUNERAL DIRECTOR Witzke		ADDRESS 4101 Edmondson Ave., 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-11431	
BIRTH NO. M-320		68-11431		CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Enes Mattucci			2. DATE AND HOUR OF DEATH 11-13-68 2:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 4901 Briarclift Road			A. STATE Md. Balto. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 4901 Briarclift Road		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9/7/90	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months: 00 Days: 00 Hours: 00 Min: 00
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Tempera			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-18-1188	17. INFORMANT Mrs. Brent Boyd, 4901 Briarclift Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES			(A) arteriosclerotic Cardio Vascular Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) cerebral thrombosis & (C) R.t. hemiplegia & aphasia		5 mos.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. #22.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Dec 18, 1956 to Nov. 13, 1968, that (I) (we) last saw the deceased alive on Nov. 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Knipp			M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-14-68
23C. PHYSICIAN'S NAME (Type) Dr. Knipp			23D. ADDRESS M.D. 4116 Edmondson Ave. Balt. Md. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/16/68	24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum		24D. LOCATION (City, town, or county) Baltimore, Maryland (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Albert E. Finkbeiner		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	

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100-12-2-10

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68-11432 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11432

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES DI NATALE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 14, 1968	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 14, 1968 1:02 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 14, 1913		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		14B. KIND OF BUSINESS OR INDUSTRY Schaffer Brewery	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-05-0261	
15. MOTHER'S MAIDEN NAME Lena Gargivlo		18. INFORMANT Mrs. Margaret DiNatale	
19. 4124		ADDRESS 5702 Kenwood Ave. Baltimore, Md 21206	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED November 14, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 18, 68	
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D NOV 16 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Lilly & Zeiler, 1901 Eastern Ave., Balto.		ADDRESS 21231	

1940

VALLEY HOTEL

EXTRA DUTY

NOV 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11433				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11433			
BIRTH NO. E.				1. NAME OF DECEASED (Type or Print) HUSBY, William					
2. DATE AND HOUR OF DEATH 11-14-68 5:55 AM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 CHURCH HOME AND HOSPITAL					
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 806 N. PATTERSON PARK AVENUE				5. CITY OR TOWN BALTIMORE					
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. STREET AND NUMBER 806 N. PATTERSON PARK AVENUE					
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-22-07			
9. AGE (In years last birthday) 61		10. If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) WASHINGTON STATE		12. CITIZEN OF WHAT COUNTRY? AMERICAN			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger				10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL					
13. FATHER'S NAME ANTHONY HUSBY				14. MOTHER'S MAIDEN NAME MARY GOODRICH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-II-1942-1945				16. SOCIAL SECURITY NO. 536-14-7122		17. INFORMANT ADDRESS Helen Husby 806 N. Patterson Park Ave.			
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days			
								OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 493X II Cerebral thrombosis	
								19A. DATE OF OPERATION 0	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10-18 1968 to 11-14 1968 , that (I) (we) last saw the deceased alive on 11-14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 11-14-68		23C. PHYSICIAN'S NAME (Type) A. E. SUBONG, JR			
23D. ADDRESS Church Home & Hospital		24. BURIAL CREMATION, REMOVAL (Specify) Burial							
24B. DATE 11-19-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler, 1901 Eastern Ave., Balto.					

WASHINGTON
D.C.

ROBERT H. HARRIS

Between
Harris
and
Robert H. Harris

11th St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11434
BIRTH NO. 68-11434				
1. NAME OF DECEASED (Type or Print) Patricia Lynn Wilson		2. DATE AND HOUR OF DEATH 11/13/68 8:40 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-43 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2531 Tolley St		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/51	9. AGE (In years last birthday) 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Wilson		
14. MOTHER'S MAIDEN NAME Dorothy Kestler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		
16. SOCIAL SECURITY NO. 3-1		17. INFORMANT Charles Samorodni M.D. Univ Hosp		
18. 273.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
19. 289.13 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). —		—		
19A. DATE OF OPERATION 0 Nov	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20A. AUTOPSY? (Yes or No) 3	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	21C. WHERE DID INJURY OCCUR? —	(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) —	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? —		
22. I certify that (I) (the hospital) attended the deceased from Oct 26 19 68 to Nov 13 19 68 , that (I) (we) last saw the deceased alive on SUN PM NOV 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Charles Samorodni M.D.		23B. DATE SIGNED 11/13		23C. PHYSICIAN'S NAME (Type) Charles S. Samorodni M.D.
23D. ADDRESS University Hospital		23E. FUNERAL DIRECTOR George L. Schwab		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-18-68	24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	24E. ADDRESS Francis H. Miller 2101 Audubon Ave
25A. DATE RECEIVED BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. ADDRESS George L. Schwab

11/17/12 11/17/12 11/17/12

University Hospital

John Wilson
Student
First white

501 Tally 21

11/17/12

Maryland
Ketter

N. 2

Chickadee

Engagement
Proposed

Captain

1700

3

Mr

Oct 12 1912

Oct 12 1912

Charles H. D.

Charles Z. Zarnowski M.D. University Hospital

11/17

FUNERAL DIRECTOR: IMPORTANT

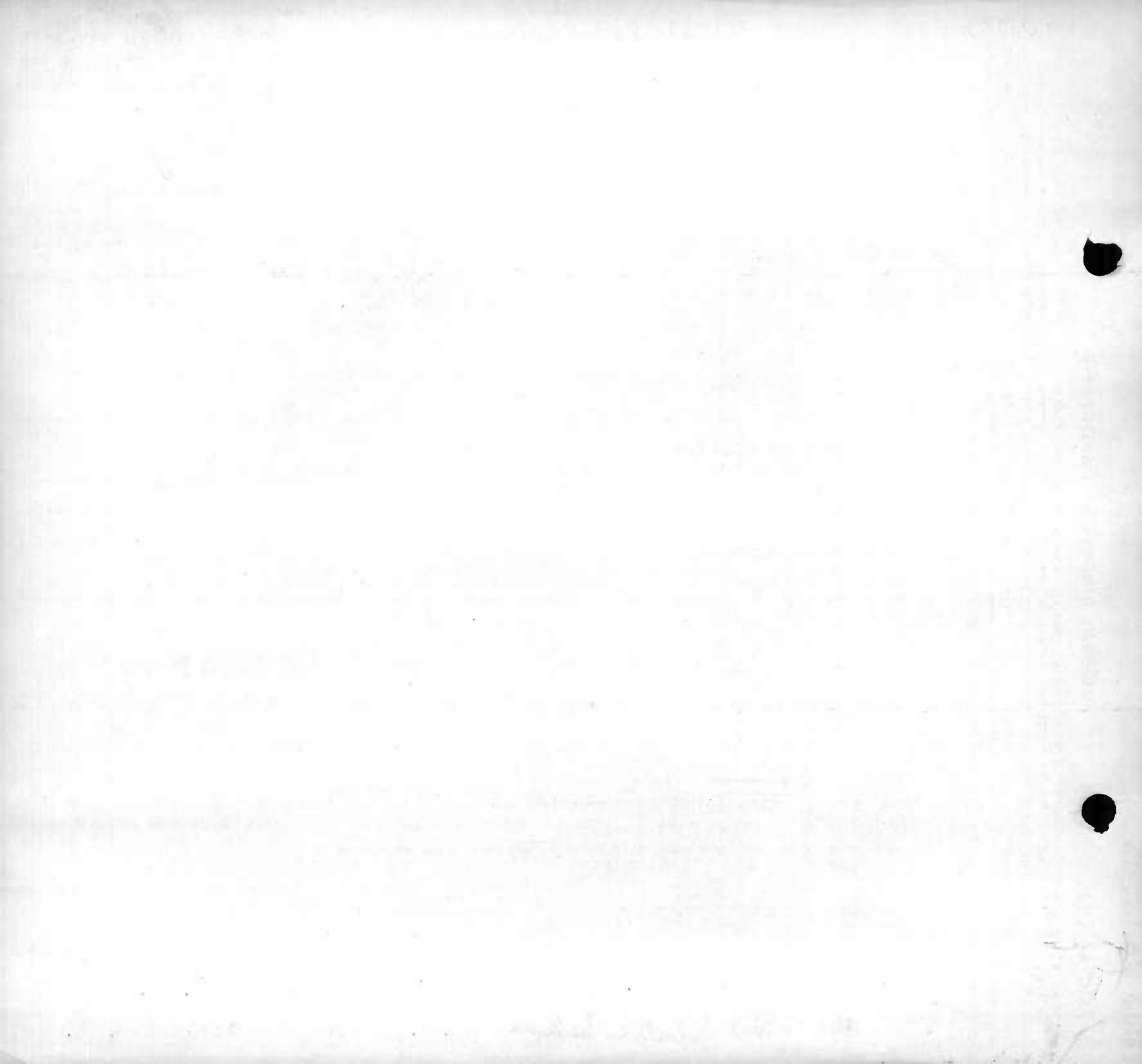
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-11435

BIRTH NO.		1. NAME OF DECEASED (Type or Print) IDA M. DERR		2. DATE AND HOUR OF DEATH 11-13-1968 6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1342 WELDON AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-09-08	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA			13. FATHER'S NAME WILLIE MASSER		
14. MOTHER'S MAIDEN NAME MAY PUTMAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-16-2477			17. INFORMANT CHART		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. CHRONIC MYELOGENOUS LEUCEMIA AND ANEMIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INDEFINITE (2 MONTHS)		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10-25-1968 to 11-13-1968 , that (1) (we) lost saw the deceased alive on 11-13-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE HUN KEE RYU				23B. DATE SIGNED 11-13-1968	
23C. PHYSICIAN'S NAME (Type) HUN KEE RYU MD				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME OF CEMETERY or CREMATORY St. Lukes Lutheran	
24D. LOCATION Frederick Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR J. F. Eline & Sons	
25D. ADDRESS Reisterstown, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-11436 CERTIFICATE OF DEATH

REG. NO. 68-11436

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENNING ALMA R.		2. DATE AND HOUR OF DEATH NOV 11 1968 5¹⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSP		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2523 W PRATT ST.		5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/9/17		9. AGE (In years lost birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM J. HENNING		14. MOTHER'S MAIDEN NAME ZELMA GALL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-6497		17. INFORMANT Mrs. Zelma G. Henning 2523 W. Pratt St. Balto. Md.	
18. 75621 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CHRONIC OBSTRUCTIVE AIRWAY DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. KYPHOSCOLIOSIS (C)..... RHEUMATIC HEART DISEASE		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 YEARS SINCE BIRTH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 7 19 68 to Nov 11 19 68 , that (I) (we) last saw the deceased alive on Nov 11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald S. Pototsky, M.D.		23B. DATE SIGNED NOV 11, 1968		23C. PHYSICIAN'S NAME (Type) RONALD S. POTOTSKY	
23D. ADDRESS M.D. UNIVERSITY HOSP. BALTO MD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 15, 1968	
24C. NAME OF CEMETERY or CREMATORY Mt. Vernon Church Cem.		24D. LOCATION (City, town, or county) (State) Phillippi., West Virginia		25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 3512 Frederick Ave, Balto. Md.	

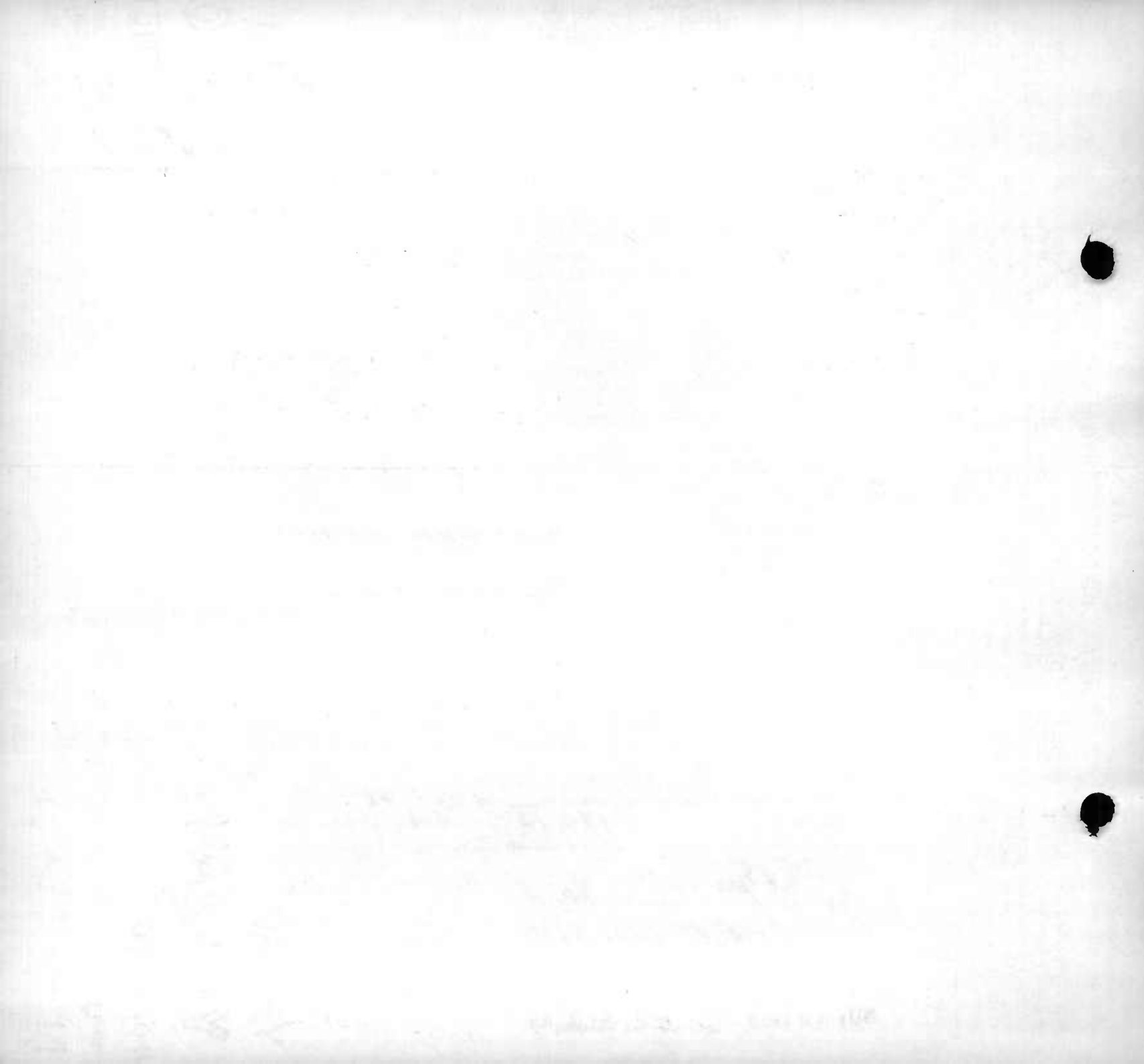
NO

Burial

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
DRAUGHN, SELMA V. B.				11-13-68 7:15 P. M.				LUTHERAN HOSPITAL OF MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)				5. CITY OR TOWN				6. INSIDE CITY LIMITS?			
Md.				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
7. STREET AND NUMBER				8. DATE OF BIRTH				9. AGE (In years last birthday)			
2628 N. LONGWOOD ST.				11-28-99				70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
DOMESTIC				PRIVATE HOMES				N.C.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				RICHARD ELLUM				MARTHA BULLOCK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
NO				214-24-7015				ED. DRAUGHN - 2628 N. LONGWOOD ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				19. CAUSE OF DEATH				20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				ACIDOSIS, DIABETES			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				ANEMIA, SEVERE DEHYDRATION			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				22. I certify that (I) (this hospital) attended the deceased from				23. DATE SIGNED			
260X II				11-7-68				11-13-68			
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? (Yes or No)			
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
23A. SIGNATURE				23B. ADDRESS				23C. PHYSICIAN'S NAME (Type)			
Jorge Garcia M.D.				LUTHERAN HOSPITAL OF MD.				Jorge Garcia M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				11/18/68				Balti. National			
25A. DATE RECEIVED BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
NOV 15 1968				Robert E. Tashner				Wm. J. CHATMAN, JR.			
26A. ADDRESS				26B. ADDRESS				26C. ADDRESS			
1701 77th Ave. S.E.				1701 77th Ave. S.E.				1701 77th Ave. S.E.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11438 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11438	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPHINE M. BETHKE		Nov. 10 th 1968 1:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
CHURCH HOME & HOSPITAL			BALTIMORE 1-03		
35			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			2523 FLEET ST.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-30-13	56 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
BETHKE GEORGE NILES		BETHKE, MARY KENNIN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MR. WM. BETHKE 2523 FLEET ST.	
18. 540.01425019 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Perforation of the Cecum 9 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 530.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Chronic Nephritis, Diabetes 2 yrs		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Nov 6 th 1968		Perforation of Cecum		/	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		None		Does not apply	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
Does not apply		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		Does not apply	
22. I certify that (1) (this hospital) attended the deceased from Nov 6 th 1968 to Nov 10 th 1968, that (2) (we) lost saw the deceased alive on Nov. 10 th 1968 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. F. AZAM M.B.B.S.				Nov 10 th 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
A. F. AZAM M.B.B.S.		Balto. MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-13-68		GARDEN OF FAITHS CEM. BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 15 1968		Robert E. Johnson		RAYMOND L. KACZOROWSKI 2525 FLEET	

CHURCH AND MEMBERSHIP

10-30-13

F W

HOUSEWIFE

WORKMAN

GEORGE WILSON

GEORGE WILSON

WILSON

Perfecting of the team

Chronic Nephritis, Diabetes

Perfecting of team

Nov 1968

Don not apply

Don not

Don not

Don not apply

Don not apply

Nov 10

Nov 10

Nov 10

Nov 10

Nov 10

Nov 10

A. J. AZAM M.B.S. D.L.S. 1931

Glenn H. H. 2

Nov 10

Nov 10

Nov 10

Nov 10 1968

68-11439

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11439

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Sister Charlotte Horst

2. DATE AND HOUR OF DEATH

November 13, 1968

5:45 A.M.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)94 Villa St. Michael
4000 Forest Hill Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland City

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4000 Forest Hill Road, 21207

5. SEX

F.

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 6, 1886

9. AGE (In years
last birthday)

82

If Under 1 Yr.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Record Librarian

10B. KIND OF BUSINESS OR INDUSTRY

Sister of Charity

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Horst

14. MOTHER'S MAIDEN NAME

Adolphine Brauns

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-48-5167-1

17. INFORMANT

Sister Andrea

ADDRESS

same address

18. 410.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary occlusion

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

General arteriosclerosis

?

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June, 1967 to November, 1968,
that (I) (we) last saw the deceased alive on November 12, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.

23A. SIGNATURE

Damian P. Alagia

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

Nov. 13, 1968

23C. PHYSICIAN'S
NAME (Type)

Damian P. Alagia

23D. ADDRESS

DEGREE

3326 Frederick Ave. Bldg 29 Md

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

Nov. 15, 68

24C. NAME OF CEMETERY or CREMATORY

St. Michael (Seton) on grounds Seton Inst., 6400 Wabash Av.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 15 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

STEWART & MOWEN CO. 108 W. North Av. Cityl

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11440 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPT. REG. NO. 68-11440

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA (Bronislawa) BRONZERT

2. DATE AND HOUR OF DEATH

November 12, 1968 11:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

719 S. Robinson Street

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/18/1901

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Bochenski

14. MOTHER'S MAIDEN NAME

Mary Lazarski

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

-

-

16. SOCIAL
SECURITY NO.

215-07-7889D

17. INFORMANT

ADDRESS

Mrs. Agnes Coffman, 3518 Woodring Ave

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) *Generalized Arteriosclerosis*
DUE TO, OR AS A CONSEQUENCE OF:

(C) *Myocardial Infarction*
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

420.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to Nov 12 19 68,
that (I) (we) last saw the deceased alive on Nov - 1 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

M. J. Janowski M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

11/13/68

23C. PHYSICIAN'S
NAME (Type)

M. J. Janowski M.D.

23D. ADDRESS

2711 Eastern Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/16/68

24C. NAME of CEMETERY or CREMATORY

Holy Rosary

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Maryland

25A. DATE REC'D. BY HEALTH DEPT.

NOV 15 1968

25B. NAME OF REGISTRAR

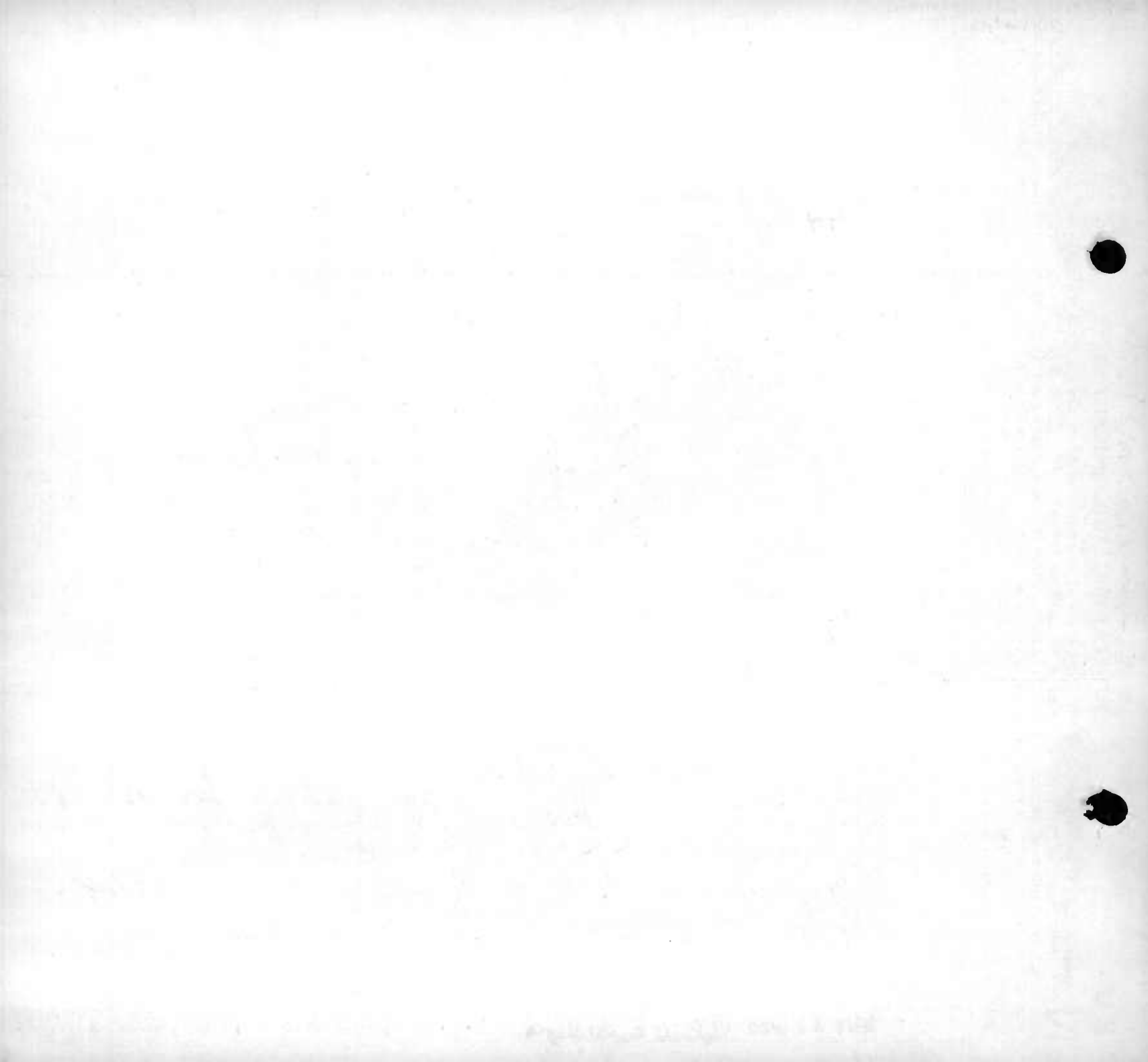
Robert E. Janowski

25C. FUNERAL DIRECTOR

M. F. SADOWSKI & SONS, 1808 EASTERN AVE.

For Copying: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEC

68-11441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

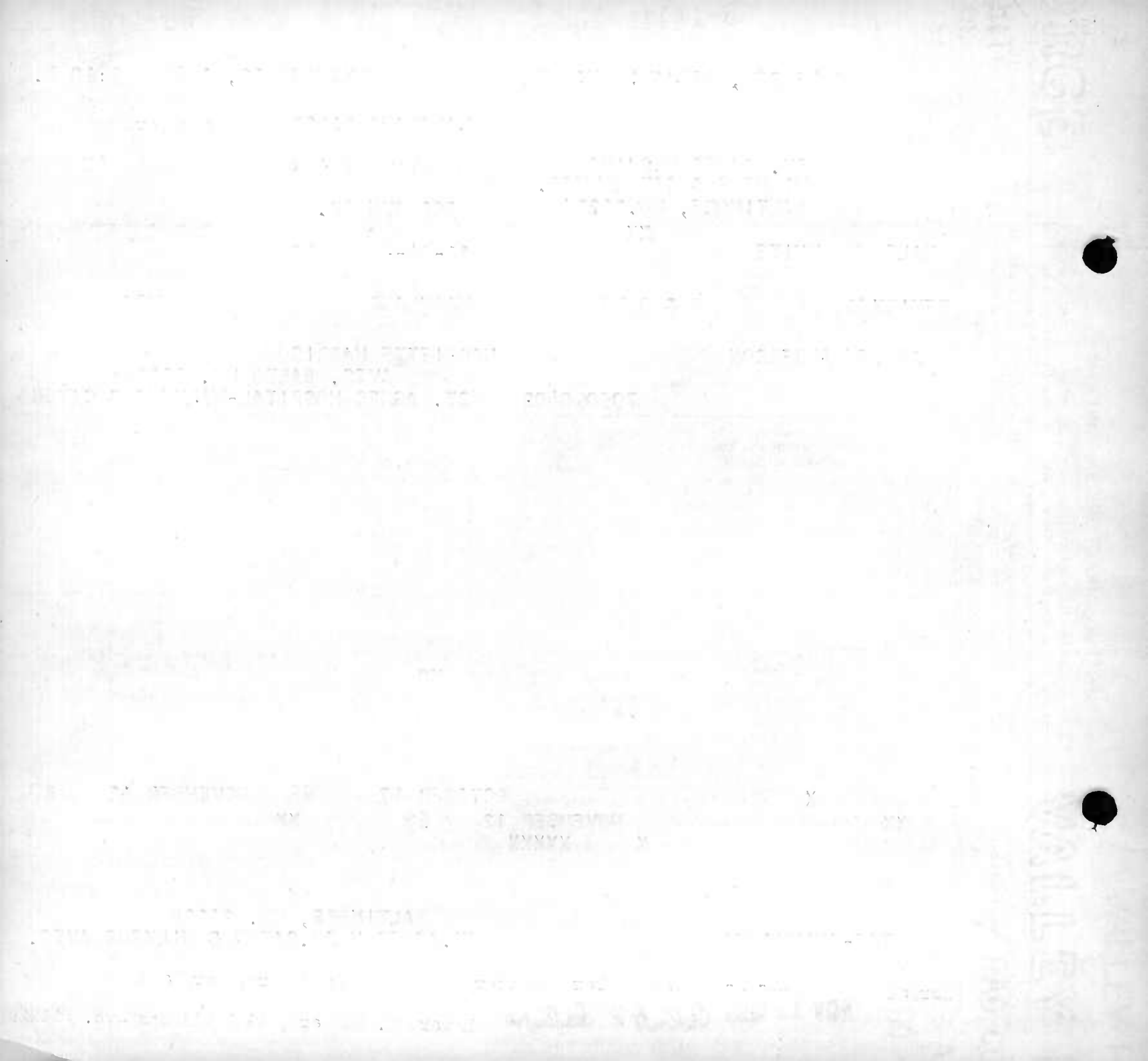
REG. NO.

68-11441

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANDERSEN, BENJAMIN HARRY		2. DATE AND HOUR OF DEATH NOVEMBER 12, 1968 7:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21227 B. COUNTY Baltimore 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN BALTIMORE Relay		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 303 GUN RD.					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-04-88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANDREW ANDERSON		14. MOTHER'S MAIDEN NAME HARRIETTE HARRISON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705090402		17. INFORMANT AVE. BALTO MD. 21229 ST. AGNES HOSPITAL-WILKENS & CATON	
18. 15719 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gastric cancer DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 13-1X II					
19A. DATE OF OPERATION Nov. 5, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED subtotal gastrectomy, resection of transverse colon		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 17 19 68 to NOVEMBER 12 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOVEMBER 12 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE Tse-Shiung Wu		23B. DATE SIGNED NOV. 12, 1968			
23C. PHYSICIAN'S NAME (Type) TSE-SHIUNG WU		23D. ADDRESS BALTIMORE, MD. 21229 ST. AGNES HOSP. CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-15-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland					
25A. DATE RECEIVED NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Fiedler		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



5-530

68-11442 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11442

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) E. SMITH Willie WILLIAM G. SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 12 68 12:50 p.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hosp.		3. DATE PRONOUNCED DEAD November 12, 1968 12:50 p	
4. SEX Male RACE Colored		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.	
6. SEX Male 7. RACE Colored B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-8-1899 10. AGE (In years last birthday) 69		E. STREET AND NUMBER 1313 W. Mulberry St.	
11. BIRTHPLACE (State or foreign country) Whitesville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME THOMAS SMITH	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Georgianna Smith	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 224-10-3595	
18. INFORMANT Mrs. Beatrice Cook		ADDRESS 532 N. Arlington Ave.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 13, 1968	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-17-68		24C. NAME of CEMETERY or CREMATORY St. Mark Church Cem.		24D. LOCATION (City, town, or county) (State) Goldsboro, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR R. E. E. Johnson		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H 1701 Laurens St.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11443

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (JOHNNIE) JOHNNIE MITCHELL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 13 68 1:58 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1805 Ruxton Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 1:58 a M.	
6. SEX MALE		7. RACE Colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-8-1912		10. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Woodland, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Amer. Smelting Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. Unk.	
15. MOTHER'S MAIDEN NAME Mrs. Eva Mitchell		ADDRESS 1805 N. Ruxton Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.2 Hypertensive arteriosclerotic cardiovascular disease		CAUSE OF DEATH Hypertensive arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Edward F. Wilson, M.D. ACTUAL SIGNATURE EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 13, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-16-68	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	

RECEIVED

1944

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WILLIAM

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-11444	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
James (Robert) Pickett				11/12/68 8:30 P.M.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY		C. CITY OR TOWN	
University Hospital				Md		18-01		D. INSIDE CITY LIMITS?	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER	
946 W. Lexington St.				Baltimore					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-12-10		58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Pool Room Operator								Black Star, S.C.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
Jeff Pickett				Mary P. McCullough Wise				USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT	
No.								Robert E. Stoner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				Auto Hemorrhagic Pancreatitis				12 hours	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Chronic Alcoholism				many years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:					
322.1 II				Subarachnoid hemorrhage				less than 24 hrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
Unknown		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Unknown					
22. I certify that (I) (this hospital) attended the deceased from 11/12/1968 to 11/12/1968, that (I) (we) last saw the deceased alive on 11/12/1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Robert E. Stoner, M.D.				11/12/68					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Robert E. Stoner				University Hospital Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11-17-68		Mt. Pilgrim Bp. Ch. Cem		Black Star S.C.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 15 1968		Robert E. Stoner		Morton E. Dyett F.H.		1704 Laurens St.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)(Virginia)
CLARA V. BANKS (Taylor)2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

November 13, 1968

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 13, 1968

12:35 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-18-1901

10. AGE (In years
lost birth day)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4414 St. Georges Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore Co., Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Harris Matthews

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

Home

15. MOTHER'S MAIDEN NAME

Zillo Harris

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No.17. SOCIAL
SECURITY NO.

18. INFORMANT

Mrs. Ruth Winder

ADDRESS

4409 St. Georges Ave

19. 412.21
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 14, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-18-68

24C. NAME of CEMETERY or CREMATORY

Cockeysville-Bazil Cem.

24D. LOCATION (City, town, or county)

Cockeysville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

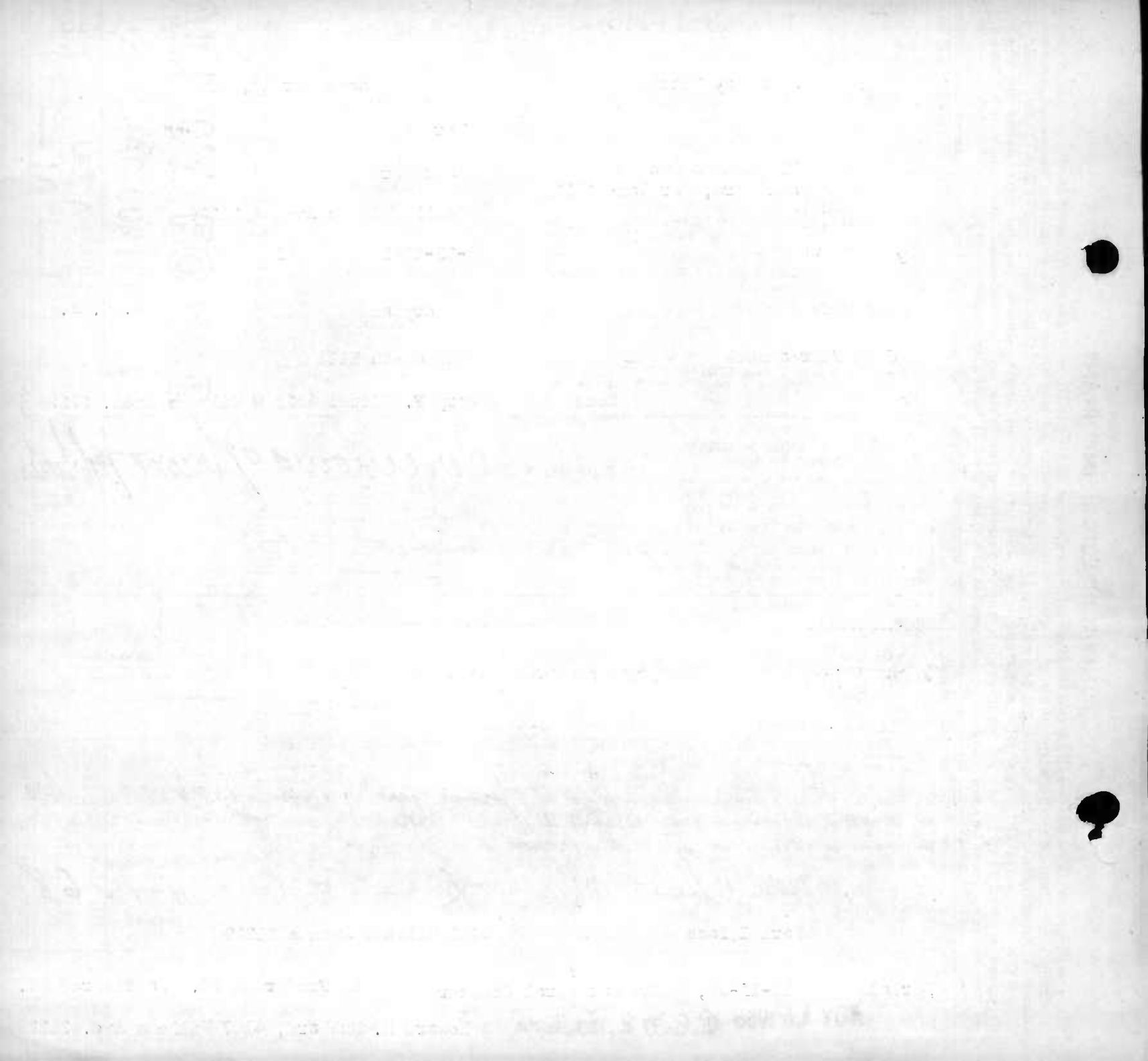
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11446 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11446

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna May Hittel		November 11, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE B. COUNTY			
		Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
00		4023 Wilkens Avenue Baltimore, Maryland 21229		Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4023 Wilkens Avenue 21229	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: It Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-23-1903	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Fuhrmanneck		Elizabeth Hill		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Henry F. Hittel 4023 Wilkens Aven. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Corcinoma of Breast			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
170X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Feb 6 1968		Corcinoma of Breast		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 26th 1968 to Nov 11 1968, that (I) (we) last saw the deceased alive on Nov 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Earl I Pass		11-12-68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Earl I Pass		4001 Wilkens Avenue 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11-15-68		New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Old Frederick Rd. Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 15 1968		Robert E. Hubbard		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



E-254

68-11447 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11447

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY Irene ECKENRODE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 10, 1968 8:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION XXXXXX XXXX 3715 Hillsdale Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 11, 1968 10:49 A.M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH July 23, 1899		10. AGE (In years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary - Md. National Bank		14B. KIND OF BUSINESS OR INDUSTRY XXXXXX XXXX 3715 Hillsdale Road #7	
15. MOTHER'S MAIDEN NAME Betty Virginia Yingling		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218-03-0424		18. INFORMANT Florence K. Eckenrode	
19. CAUSE OF DEATH 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH Ellicott City, Md.	
20A. DATE OF OPERATION 422.1 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 11/11/68 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-15-68	
24C. NAME OF CEMETERY or CREMATORY Westminster Cemetery		24D. LOCATION (City, town, or county) (State) Westminster, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hgts. Ave	

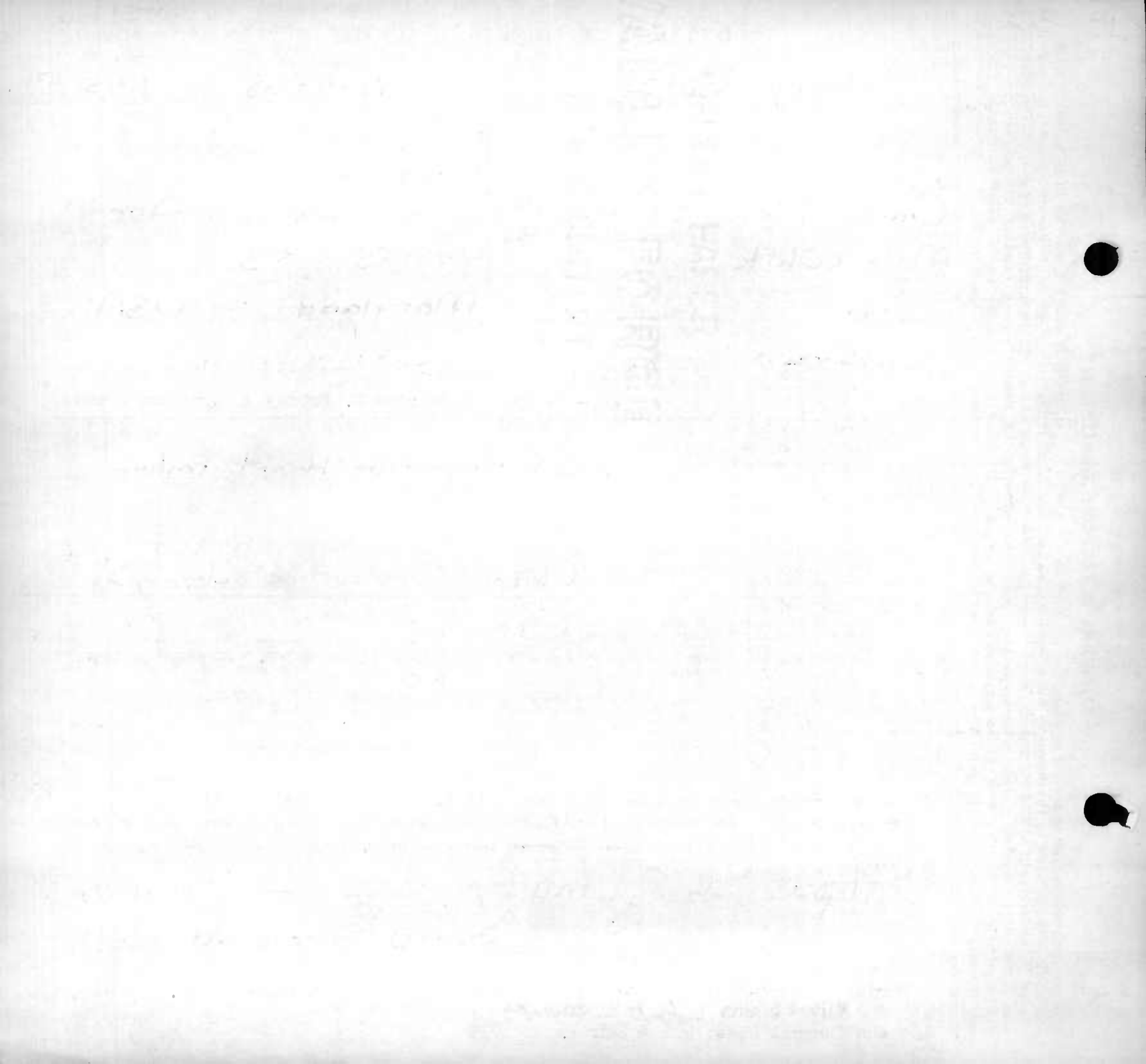
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11448 CERTIFICATE OF DEATH

REG. NO. 68-11448

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Henry Butz		2. DATE AND HOUR OF DEATH 11-11-68 11:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3406 Roselawn Ave 14	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-85	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glaizer		10B. KIND OF BUSINESS OR INDUSTRY Camkan Bros.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown Henry Butz			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-01-3495		17. INFORMANT Katherine C. Butz 3406 Roselawn Avenue
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 517.21 Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Obstructive Pulmonary Dis. 327.2 II Uremia OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 11-09 19 68 to 11-11 19 68 , that (H) (we) last saw the deceased alive on 11-11 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen J. Gady MD				23B. DATE SIGNED 11-11-68	
23C. PHYSICIAN'S NAME (Type) Stephen J. Gady				23D. ADDRESS 2511-0 Steele Rd Balt.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-14-1968		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore Co. Md		24E. FUNERAL DIRECTOR Lassahn Funeral Home			
25A. DATE RECEIVED NOV 18 1968		25B. NAME OF REGISTRAR Robert E. Williams		25C. FUNERAL DIRECTOR ADDRESS 7401 Belair Road 21236	



FUNERAL DIRECTOR: IMPORTANT

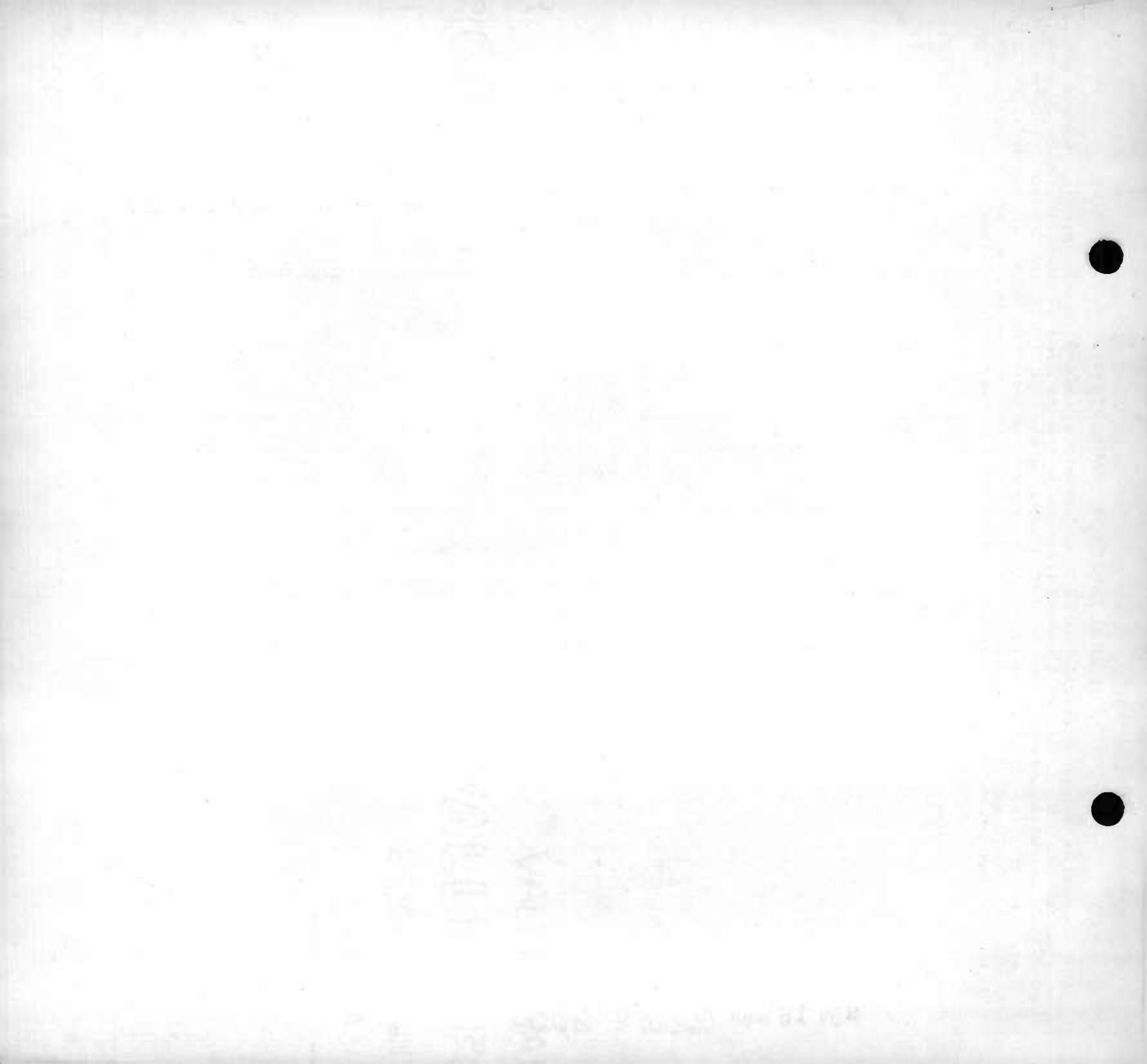
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11449 CERTIFICATE OF DEATH

REG. NO.

68-11449

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARL W. DORNHEIM		2. DATE AND HOUR OF DEATH 11/13/68 3:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN CATONSVILLE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 23 MONTROSE MANOR CT.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/3/95	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL		10B. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (State or foreign country) R.I.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME RUDOLPH DORNHEIM			
14. MOTHER'S MAIDEN NAME CRISTINA PETER				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI	
16. SOCIAL SECURITY NO. 038019371		17. INFORMANT HOSP. REC.			
18. 4-31-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRO VASCULAR ACCIDENT - PROBABLE INTRACRANIAL HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATHEROSCLEROSIS		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 331X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 12 1968 to Nov. 13 1968 , that (I) (we) last saw the deceased alive on Nov. 13th 1968 3:00 a.m. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. M. Revilla				23B. DATE SIGNED 11/13/68	
23C. PHYSICIAN'S NAME (Type) R. M. REVILLA M.D.		23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11/15/68	24C. NAME OF CEMETERY or CREMATORY BALTO. NATL.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968	25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR E.S. MALNABIS		ADDRESS 21228



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11450		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11450	
BIRTH NO. 65-07374					
1. NAME OF DECEASED (Type or Print) SANDRA RINGER			2. DATE AND HOUR OF DEATH 11/14/68 12²⁰ AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BART 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33			C. CITY OR TOWN ESSEX (21221) D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 910 KINWAT AVE					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/65	9. AGE (In years lost birthday) 3	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME LLOYD RINGER			14. MOTHER'S MAIDEN NAME NAOMI RINGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO DE		17. INFORMANT Lloyd D. Ringer Same	
18. 207.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: E. Coli INFECTION 2 days		
			(B) LEUKEMIA (STEM CELL) 20 months DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 207.4 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/18/68 19 to 11/14 19 68 , that (I) (we) last saw the deceased alive on 11/13/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald O. Rieder, MD				23B. DATE SIGNED 11/14/68	
23C. PHYSICIAN'S NAME (Type) RONALD O. RIEDER				23D. ADDRESS JOHNS HOPKINS HOSP.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/14/68		24C. NAME OF CEMETERY or CREMATORY Harned Memorial Home	
24D. LOCATION Brandonville, W. Va.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR James E. Brudzinski	
25D. ADDRESS 1407 Eastern Ave. 21221					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.				68-11451							
1. NAME OF DECEASED (Type or Print) <u>Edward J. Lee</u>								2. DATE AND HOUR OF DEATH <u>11/17/68</u> <u>3:15</u> a.m.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1-01</u>											
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>				C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
31								E. STREET AND NUMBER <u>927 SOUTH STREEPER STREET</u> <u>#21224</u>											
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-19-19</u>		9. AGE (In years last birthday) <u>49</u>		If Under 1 Yr. Months Days Hours Min.		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John</u>								14. MOTHER'S MAIDEN NAME <u>Mary</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>				16. SOCIAL SECURITY NO. <u>218-118-6666</u>				17. INFORMANT <u>BALTIMORE CITY HOSPITALS</u> <u>RECORDS: 4940 EASTERN AVENUE</u> <u>#21224</u>				ADDRESS							
18. <u>486X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Congestive</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____																			
19. DATE OF OPERATION <u>2</u>								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <u>11-11-</u> <u>19 68</u> to <u>11-12-</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>11-12-</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>W.W. MacDonald M.D.</u>								Attending <input type="checkbox"/> Med. <input type="checkbox"/> Staff <input checked="" type="checkbox"/> Phys. Director Phys.				23B. DATE SIGNED <u>11/12/68</u>							
23C. PHYSICIAN'S NAME (Type) <u>W.W. MACDONALD M.D.</u>								23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>#21224</u>											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>11/15/68</u>				24C. NAME OF CEMETERY or CREMATORY <u>BALTO. CEM.</u>				24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>							
25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 18 1968</u>								25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>				25C. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u> <u>300 MALE</u>							

Received

~~of~~

Corporate stock

x

Wm. A. Carroll

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-11452
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES O WEST (COREY)		2. DATE AND HOUR OF DEATH Nov. 11, 1968 5:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTO. CITY HOSP			C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE 6. RACE WHITE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 84
11. BIRTHPLACE (State or foreign country) W. VA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James			14. MOTHER'S MAIDEN NAME Sarah BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNLS			16. SOCIAL SECURITY NO.		17. INFORMANT 4940 EASTERN AVE. BCH: RECORDS BALTIMORE, MD. 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.8 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: 1. METASTATIC CA. IN LUNG 2. LARGE BOWEL CARCINOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr.
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 153.8 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/11/68 to 11/11/68 and that (I) (we) lost saw the deceased alive on 11/11/68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Rosenbaum				23B. DATE SIGNED 11/11/68	
23C. PHYSICIAN'S NAME (Type) Robert A. Rosenbaum				23D. ADDRESS BALTIMORE CITY HOSPITALS #21224 4940 EASTERN AVE. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 11/11/68		24C. NAME OF CEMETERY or CREMATORY SPENCER	
24D. LOCATION W. VA		24E. DATE REC'D BY HEALTH DEPT. NOV 15 1968		24F. NAME OF REGISTRAR Robert E. Finkbeiner	
24G. FUNERAL DIRECTOR J. G. CONNELLY SONS		24H. ADDRESS 300 MACE			

E-245

68-11453 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11453

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER M. EKHOLM		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 12 68 10:50p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospital 3-25-69		3. DATE PRONOUNCED DEAD Month Day Year Hour November 12, 1968 10:50 P	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00			
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Dec. 27, 1934		10. AGE (In years last birthday) 33 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Co. Health Department		15. MOTHER'S MAIDEN NAME Mary Morris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1955-1963		17. SOCIAL SECURITY NO. 219-32-5401	
18. INFORMANT (Wife) Mrs. Linda L. Ekholm, Ave. A. Box 179 A Rt. 10		ADDRESS Balto. Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E98012		CAUSE OF DEATH Elavil intoxication	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E8789 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fatty Liver	
20A. DATE OF OPERATION 3		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fatty Liver	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Unknown		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unknown		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) Unknown	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		DATE SIGNED November 13, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

N970.09680021450

Letter from M.E.'s office 3-25-69 M.H.

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68-11454 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11454

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VERA GILLIN (GILLARD) 2. DATE OF DEATH Known ☐ Estimated ☐ November 8, 1968 11:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL (DOA) 3. DATE PRONOUNCED DEAD November 8, 1968 11:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

6. SEX Female 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. DATE OF BIRTH 4/16/46 10. AGE (In years lost birthday) 22 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HENRY GILLARD 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 15. MOTHER'S MAIDEN NAME MARIE RICHARDSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 18. INFORMANT (BETTY) SISTER 33 S. FRANKLIN TOWNE Rd.

19. E9661X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Stab wound of Abdomen

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2446 Callow Avenue 13-01

22D. TIME (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Stabbed during altercation

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED November 9, 1968

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 11-13-68 24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN BALTO. Md.

25A. DATE RECEIVED BY HEALTH DEPT. NOV 15 1968 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR I. L. BROWN & SON 123 W. MONTGOMERY ST.

(M. H. H.)

1/16/16

W. H. H.

HENRY GILBERT

MARIE RICHARDS

(BETTY) since 1916

W. H. H.

1/16/16

11-13-16 Mount Hesperia Photo. M. H.

NOV 13 1916

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11455
BIRTH NO. 68-11455		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Margaret Harrison		2. DATE AND HOUR OF DEATH Nov. 14, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1031 Brantley Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1601 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1031 Brantley Ave.		
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1897	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME Annie Jones		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Normon Harris 1010 Bennett Pl.		
18. 18291 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Uterus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: 174X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertensive Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Arkn				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 25 1963 to Nov 14 1968 , that (I) (we) last saw the deceased alive on Nov 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE H. Garland Chissell DEGREE		23B. DATE SIGNED Nov 15, 1968		23C. PHYSICIAN'S NAME (Type) H. Garland Chissell DEGREE
23D. ADDRESS 1038 Edmondson Ave Baltimore Md		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE Nov. 18, 1968		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Broadway ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11456 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68-11456

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sarah Long</u>		2. DATE AND HOUR OF DEATH <u>11/14/68</u> <u>12:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>14-03</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1900 McCulloch St</u>		5. SEX <u>Female</u> 6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>4/19/12</u>		9. AGE (In years lost birthday) <u>56</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Sasha Long</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Parrying</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>9/2-72-9735</u>		17. INFORMANT <u>Charles S. Samorodin M.D. Univ. Hosp.</u> ADDRESS	
18. <u>180X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal failure - hepatic coma</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CA cervical metastasis</u> (C) _____	
171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>?</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (I) (this hospital) attended the deceased from <u>11/5/68</u> 19 to <u>11/14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/14/68</u> 19 <u>12:00 PM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.			
23A. SIGNATURE <u>Charles S. Samorodin M.D.</u> DEGREE				23B. DATE SIGNED <u>11/14</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles S. Samorodin M.D.</u> DEGREE		23D. ADDRESS <u>Univ. Hospital</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/19/1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem. Balto. Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
25C. FUNERAL DIRECTOR <u>Williams Funeral Home 319 N. Salisbury St</u>		25D. ADDRESS			

University Hospital

Fr. 1914

Dr. 1914
2nd floor

4th floor

Medical

2nd floor

2nd floor - 2nd floor

Room 101 - 1st floor
C. 101

CA 101 - 1st floor

11/12/14
11/12/14

Chickadee

Charles 2. 2nd floor

Room 11/12/14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11457	
BIRTH NO. 68-19663		68-11457	
1. NAME OF DECEASED (Type or Print) BABY BOY CHASE		2. DATE AND HOUR OF DEATH 11/13/68 11:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1601	
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MD. HOSPITAL		C. CITY OR TOWN BALTO.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 943 W. Fayette St	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 8
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CALVIN CHASE		14. MOTHER'S MAIDEN NAME CLIFFORDTINE ROYAL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Cliffordtine Chase 943 W. Fayette St
18. 776.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC RESP. FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. IMMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 773.3 II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/5/68 to 11/13/68 , that (I) (we) last saw the deceased alive on 11/13/68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE John Synatowski M.D.		23B. DATE SIGNED 11/13/68	
23C. PHYSICIAN'S NAME (Type) John Synatowski M.D.		23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/16/68	
24C. NAME of CEMETERY or CREMATORY St. Calixtus Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Williams Funeral Home		25D. ADDRESS 319 N. Calhoun St	

12/10/1914

infant

W

University Hospital

Received of the Registrar of Companies

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

TOBACCO GROWING

COMPARING FATTY MATTER -
WEIGHTS OF FATTY

1885-1886

1886

Received of the Hon. Mr. [illegible] the sum of \$100.00
for the purchase of [illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11459

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALICE PAULINE HERSHEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 13, 1968 5:35 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 13, 1968 5:35 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July 7, 1928	10. AGE (In years last birthday) 40	E. STREET AND NUMBER 2042 Park Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Ada Kelly	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Thelma Floyd 425 Roundview Rd		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 988 X		CAUSE OF DEATH Subdural Hematoma complicated by bronchopneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 936.9 II		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2 10/13/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNK?		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) UNK?	
22D. TIME OF INJURY (APPROX.) UNK?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) UNK?		22F. HOW DID INJURY OCCUR? Found lying beside bed	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 16, 1968	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Westport Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. J. [Signature]	
25C. FUNERAL DIRECTOR Joseph H. [Signature]		ADDRESS 2222 W. North Ave	

WALL GLEY 120113

EX-110113

NOV 15 1960

H-200

68-11460 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11460

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LAWRENCE HAYES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 10, 1968 Hour 1:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 10, 1968 1:45 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-9-17		10. AGE (In years lost birthday) 51 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 6/23/42*1/15/46		17. SOCIAL SECURITY NO.	
18. INFORMANT Rosalie Hayes		ADDRESS 3022 Auchentoroly Ter	
19. 412.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 422.1 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-18-68	
24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968 Robert E. Finkbeiner		25B. NAME OF REGISTRAR V.R. Bailey	
25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

210

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
68-11461 CERTIFICATE OF DEATH**

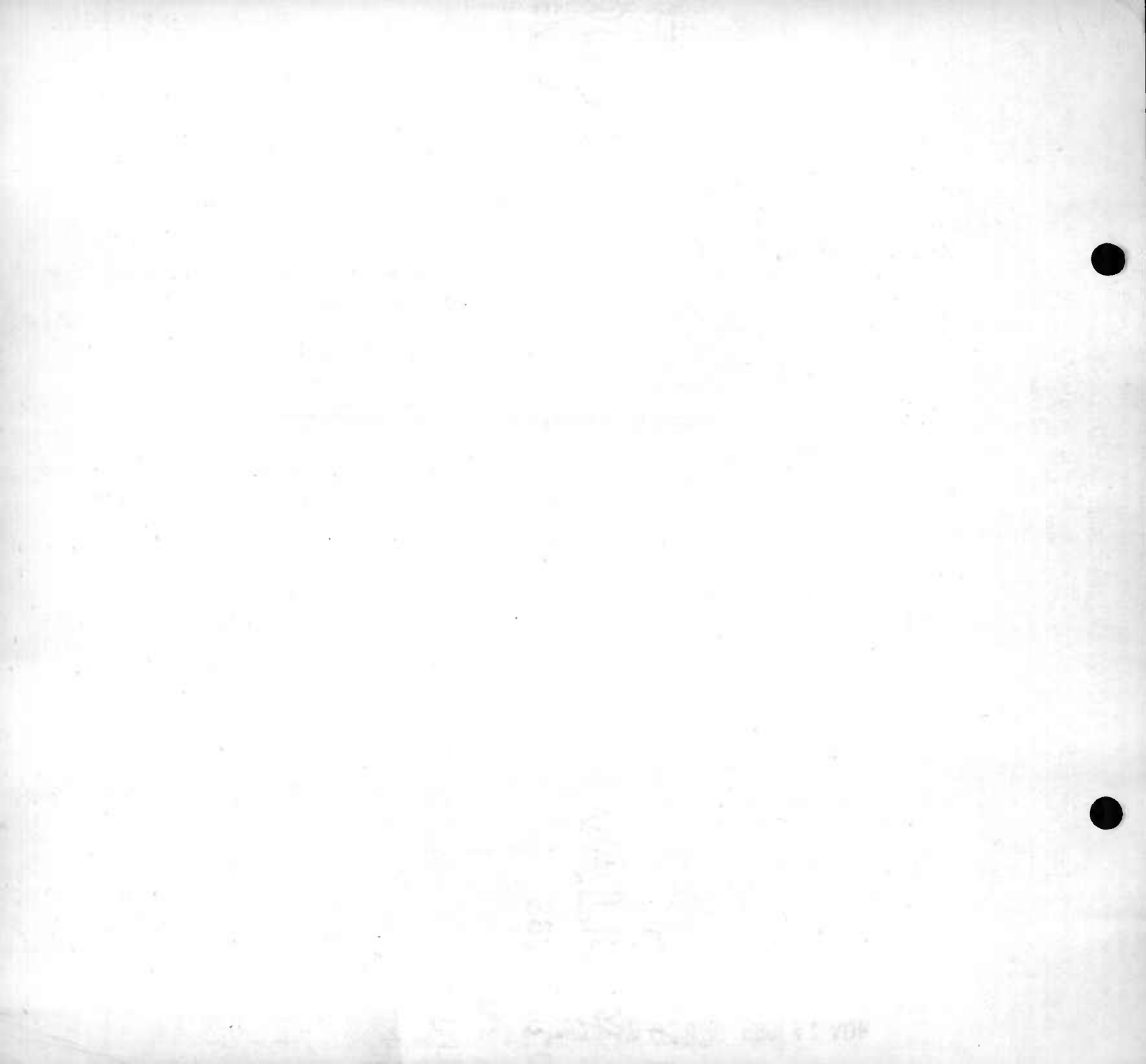
REG. NO. **68-11461**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bessie Sneed</i>		2. DATE AND HOUR OF DEATH <i>11-13-68</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>3406 Carlisle Ave</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>6-11-1881</i> 9. AGE (In years last birthday) <i>87</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY?		11 Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME <i>James Pratt</i>		14. MOTHER'S MAIDEN NAME <i>Elisa</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Florence Williams</i>		ADDRESS <i>same</i>	
18. <i>428X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1wk.	
(B) Myocardial Insufficiency DUE TO, OR AS A CONSEQUENCE OF:		(C)		10 yrs.	
19A. DATE OF OPERATION <i>422.2 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <i>1962</i> to <i>13 Nov. 1968</i> , that (I) (we) last saw the deceased alive on <i>13 Nov. 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joshua R. Mitchell III</i>		23B. DATE SIGNED <i>15 Nov. 68</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSHUA R. MITCHELL III M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-16-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Sullivan Funeral Home</i>		25D. ADDRESS <i>1011-13 N. Arlington Ave</i>		25E. DATE OF DEATH <i>11-13-68</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

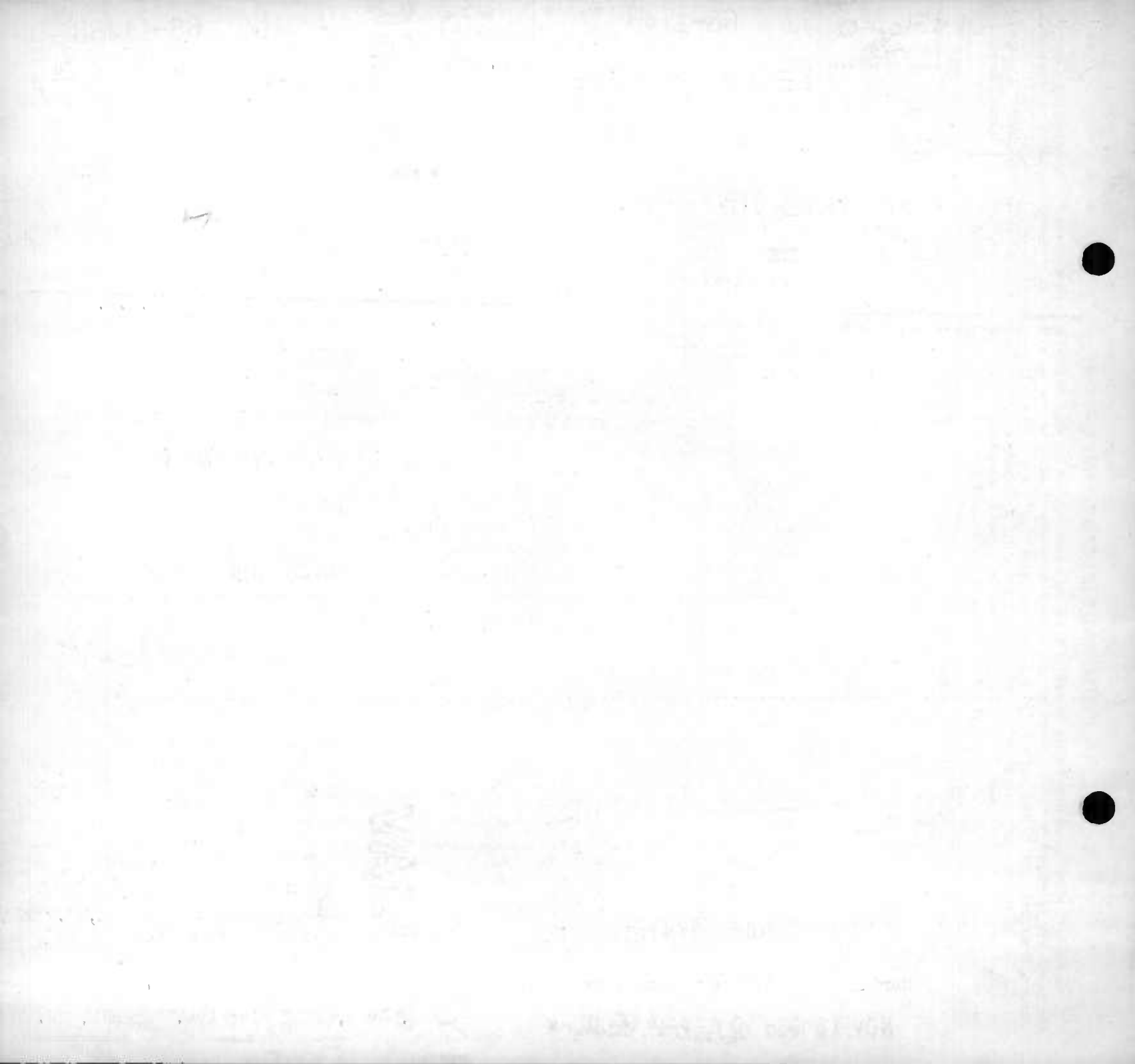
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-11462	
BIRTH NO. 68-11462		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr. John H. Plater		2. DATE AND HOUR OF DEATH 11/11/68 8 45/ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		A. STATE Wash. D.C.		B. COUNTY V-48	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Washington, D.C.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER 817 R St. N.W.			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/04/24	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Charles Co., Maryland	
13. FATHER'S NAME WM J. PLATER		14. MOTHER'S MAIDEN NAME Ida Woodland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary R. Branson Box 216-A Bryano Road, Md.	
18. 141.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE HEMORRHAGE FROM THROAT.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive Hemorrhage from throat.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes or less	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Squamous Cell Carcinoma of tongue + throat		(B) DUE TO, OR AS A CONSEQUENCE OF: Squamous Cell Carcinoma of tongue + throat		(C).....	
19. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 10/28		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 68 to 11/11 19 68 , that we lost the deceased alive on 11/11/68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.					
23A. SIGNATURE Delmar H. Knudson MD		23B. DATE SIGNED 11/11/68		23C. PHYSICIAN'S NAME (Type) Delmar H. Knudson MD	
23D. ADDRESS 1816 E. Monument St, Balt, Md		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-16-1968		24C. NAME OF CEMETERY or CREMATORY St. Catherine's Cemetery		24D. LOCATION (City, town, or county) (State) Briantown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leroy E. Berry Rt. 224 Pomonkey, Md. 20640	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-11463	
1. NAME OF DECEASED (Type or Print) BESSIE M. KRAGE		Bessie M. Krage		2. DATE AND HOUR OF DEATH NOVEMBER 12, 1968 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 4940 EASTERN AVENUE #21224 BALTIMORE CITY HOSPITALS			A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1901 QUEENSWAY #21222		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/94	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY NEW JERSEY		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME WILLIAM BAULSIR			14. MOTHER'S MAIDEN NAME BESSIE MITCHELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 057-14-2297-JI		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224	
18. 209X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYELOFIBROSIS ARTERIO-SCLEROTIC CARDIO-VASC. DISEASE					
292.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). URINARY TRACT INFECTION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 19 68 to 11/12 19 68 , that (I) (we) last saw the deceased alive on 11/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Torres				23B. DATE SIGNED 11/12/1968	
23C. PHYSICIAN'S NAME (Type) JOSE TORRES MD.		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224 BALTIMORE CITY HOSPITALS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/16/68		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Fashina		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

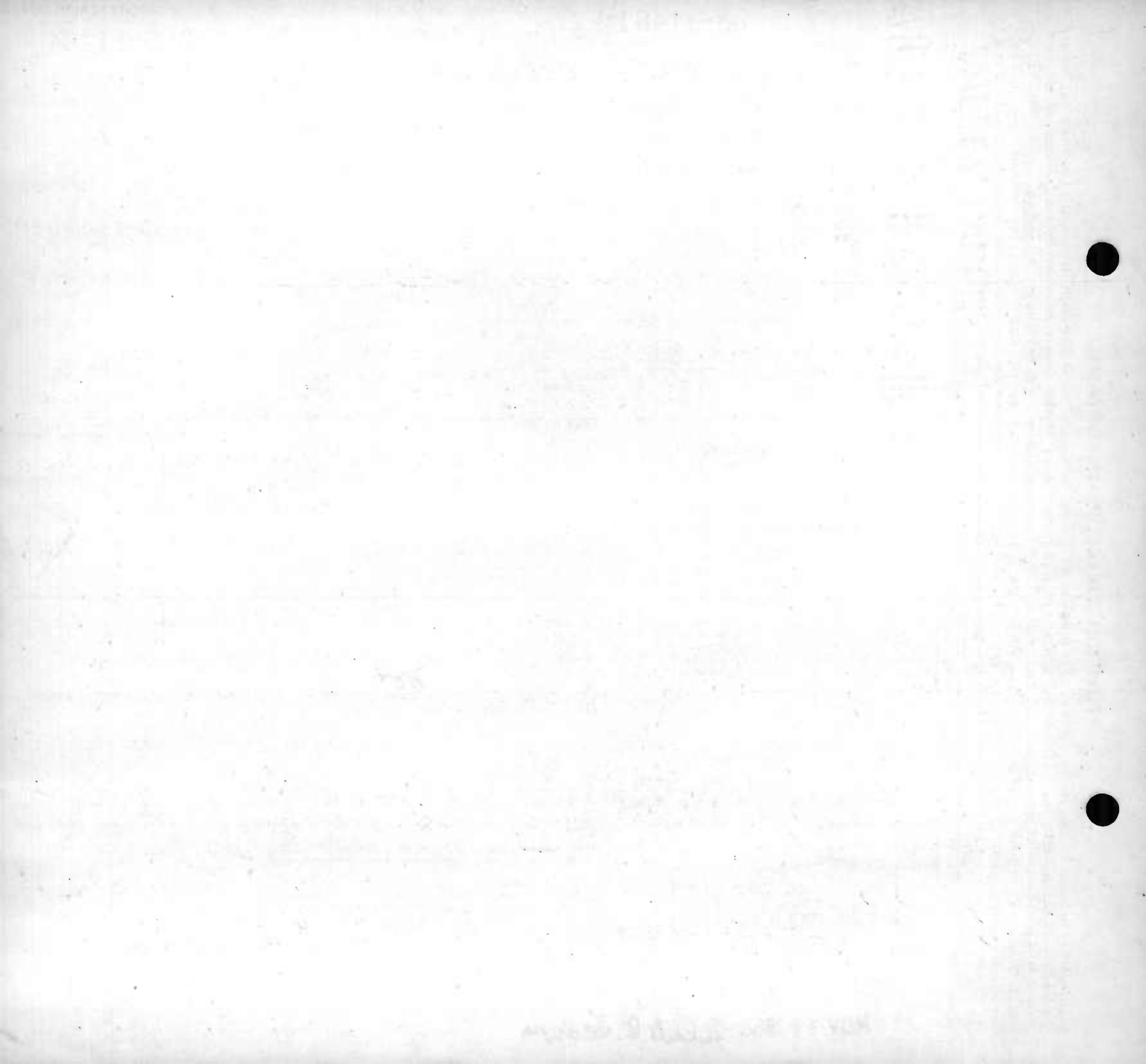
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11464

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HELEN MARIE COLLIER		2. DATE AND HOUR OF DEATH 11/15/68 7:40 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hospital BALTIMORE - Md 21218		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 3/5/1902 9. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Anthony Gritz	
14. MOTHER'S MAIDEN NAME LENA DEITZ		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-2909	
17. INFORMANT Ruth L. Collier Daughter in Law		ADDRESS Same		18. 1977.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA OF LUNG (Primary?) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Generalized Arteriosclerosis	
19. DATE OF OPERATION 165X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/29/68 to 11/15/68 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/15/68 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Zaher Ud Din		23B. DATE SIGNED 11/15/68		23C. PHYSICIAN'S NAME (Type) ZAHER UD DIN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/19/68		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. ADDRESS (State)			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11465

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine ALCANTARA		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> November 11, 1968 Hour 3:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 810 S. Linwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour November 11, 1968 10:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Dec. 19, 1908	10. AGE (In years last birthday) 59	E. STREET AND NUMBER 810 S. Linwood Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Continental Can Co.		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Eleanor Kempksi		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-03-2381		18. INFORMANT (Son) Parkvue Rd. Rt. #2 Box 69L Mr. Emmanuel C. Alcantara, Fallston, Md.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/12/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/15/58	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE RECEIVED BY HEALTH DEPT. NOV 15 1968		25B. NAME OF REGISTRAR Robert E. Gidycz	25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 2829 Hudson St. Balto. Md.

WALTER H. HORN

1914-1915

1914-1915

1914-1915

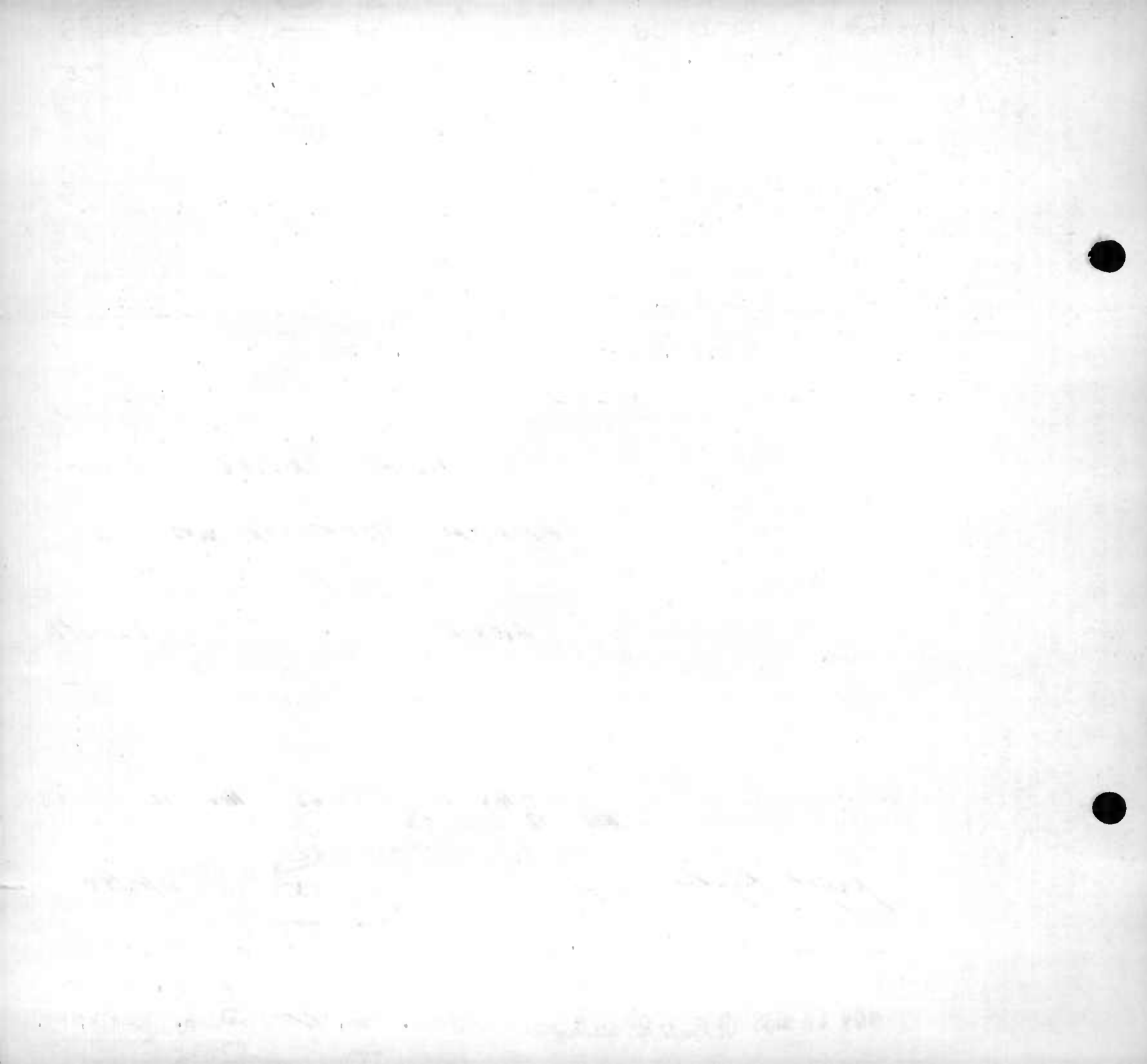
1914-1915

1914-1915

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>N-425-68-11466</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-11466</u>	
1. NAME OF DECEASED (Type or Print) <u>George C. Nelson</u> <u>GEORGE C. NELSON</u>				2. DATE AND HOUR OF DEATH <u>11-12-68</u> <u>5:55</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVE. BALTIMORE, MD</u> <u>#21224</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTIMORE</u> <u>53-00</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>1209 RIDGESHIRE RD. BALTIMORE, MD.</u>		#21222	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-14</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired- Bethlehem Steel Co.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas C. Nelson</u>			14. MOTHER'S MAIDEN NAME <u>ELLA D. Watson</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1938-1941</u>			16. SOCIAL SECURITY NO. <u>224-126-634</u>		17. INFORMANT <u>BCH: RECORDS</u>		
			ADDRESS <u>4940 EASTERN AVE,</u>		<u>BALTIMORE, MARYLAND # 21224</u>		
18. <u>185X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC FAILURE</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>METASTATIC PROSTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 year</u>	
(C) _____							
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ANEMIA</u>						<u>1 month</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> 19 <u>68</u> to <u>Nov. 12</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 12</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joseph Kaplan M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/12/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH KAPLAN M.D.</u>				23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVE. BALTIMORE, MD. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/15/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11467 CERTIFICATE OF DEATH				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Chester L. Hilker Hilker Mr. Chester L.		11-12-68 9.46 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Maryland General Hospital 48 Maryland General Hospital				Baltimore Edgemere 53-00	
E. STREET AND NUMBER				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2617 Manor Ave					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
3-15-96		72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
Laborer-Bethlehem Steel Co.				Pa.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Pa.				U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
John H. Hilker				Lyda Fisher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
Yes				WWI 213-07-9588A	
17. INFORMANT (Wife)				ADDRESS	
Mrs. Clara Hilker, 2617 Manor Ave.				Edgemere, Md. 21219	
18. 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				ANTERIOR CORONARY HEART DISEASE	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cardio-respiratory arrest	
(B) Sub-arterial myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:				obstructive jaundice, lymphoma, secondary in liver	
420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				① IMPACTED GALL STONES IN CBD ② PULMONARY EMPHYSEMA ③ ? LYMPHOMA	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10. 11. 1968 to 11. 12. 1968, that (I) (we) last saw the deceased alive on 11. 12. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Mohammad Sidig		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		11/12/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR ADDRESS	
MOHAMMAD SIDIG M.B.B.S.		Maryland General Hospital		John J. Duda, 7922 Wise Ave. Dundalk, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/15/68		Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. DATE RECEIVED	
Baltimore, Maryland		NOV 16 1968		John J. Duda	

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

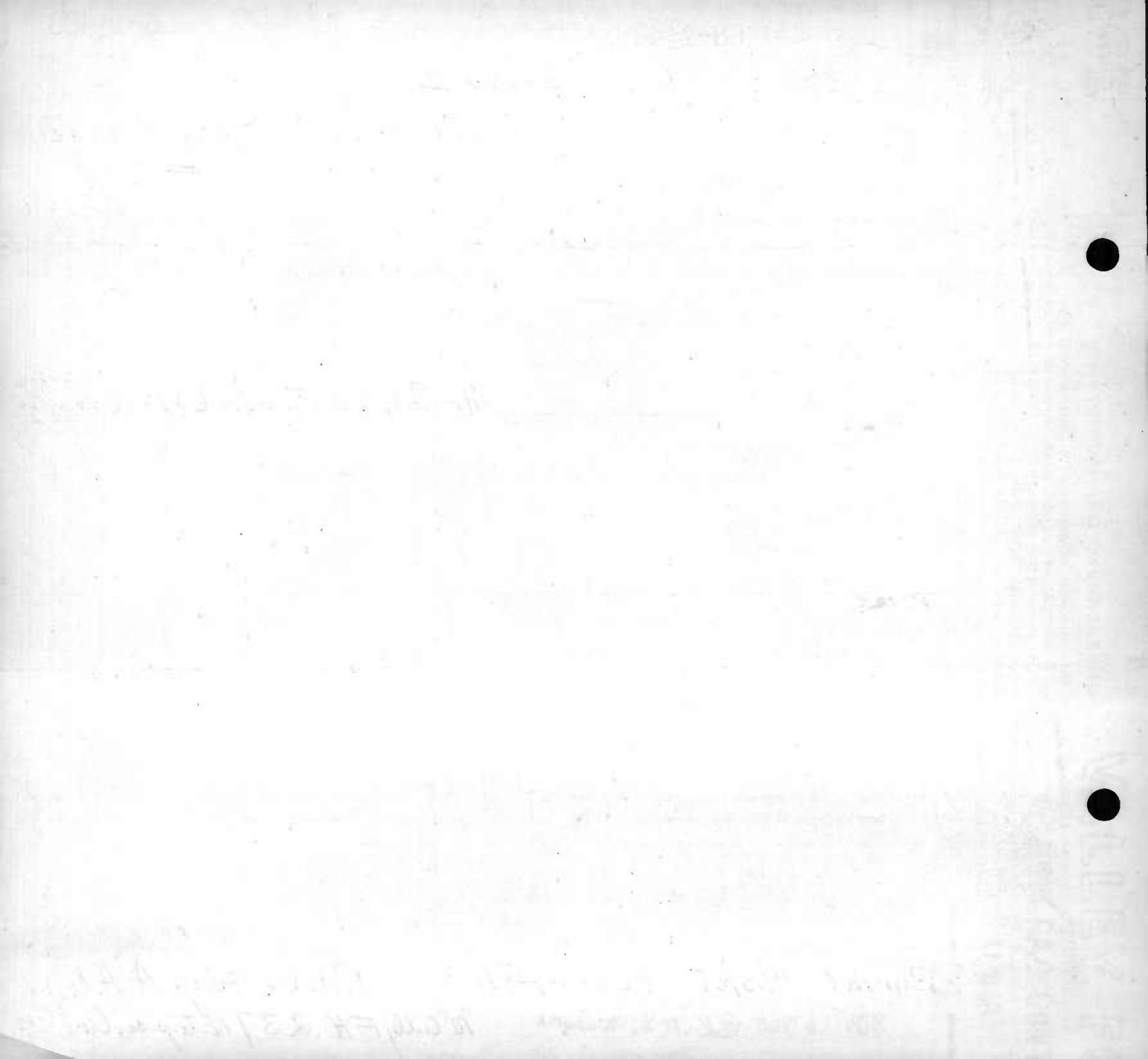
10. 11. 15. 20. 25. 30. 35. 40. 45. 50. 55. 60. 65. 70. 75. 80. 85. 90. 95. 100.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>68-11468</u> |
|--|---------------------|---|------------------------------------|---|
| BIRTH NO. <u>68-02614</u> | | 68-11468 CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>FORD; RALPH Ervan III</u> | | 2. DATE AND HOUR OF DEATH
<u>11.13.68</u> <u>5 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNIVERSITY OF MARYLAND</u>
<u>38 HOSPITAL</u> | | C. CITY OR TOWN <u>6212 PENNINGTON AVE</u> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER <u>BALTIMORE, Md.</u> <u>25-05</u> <u>2126</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2.10.68</u> | 9. AGE (In years last birthday)
<u>89</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> |
| 13. FATHER'S NAME
<u>RALPH FORD JR.</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARIAN ALLMAN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Mr Ralph E Ford Jr.</u> ADDRESS <u>2126</u> |
| 18. <u>746.6 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Coronary Failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>Mitral Stenosis</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>—</u> | | |
| 18. <u>754.5 II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Mths</u> | | |
| 19A. DATE OF OPERATION
<u>11.13.68</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Mitral Stenosis</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not White <input type="checkbox"/>
Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1968</u> to <u>11.13 1968</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>11.13 1968</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Garvey</u> | | 23B. DATE SIGNED
<u>11.13.68</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>GARVEY</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>11/15/68</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Pedar Hill</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>Ritchie Hwy. A.A. Co. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 15 1968</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR
<u>McCurly F.H.</u> ADDRESS <u>237 Patapsco Ave</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 68-11469 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 68-11469 | |
|---|----------------------------|--|---|--|---|---|--|
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Frances Clary</i> | | | | 2. DATE AND HOUR OF DEATH
<i>11-9-68 7:30 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>524 N. Chester St. Baltimore, Md.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>524 N. Chester St.</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>3/22/1889</i> | 9. AGE (In years last birthday)
<i>79</i> | 10. Under 1 Yr.
Months: Days: Hours: Min. | 11. Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Burly Town, W. Va.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Grover Behan</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Sarah (last name unknown)</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>212-54-7851</i> | | 17. INFORMANT
<i>Charles Clary</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
174X I
<i>Carcinoma of breast</i> | | CAUSE OF DEATH
(A) DUE TO <i>metastatic</i>
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 yr.</i> | | | |
| 170X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>Oct 67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 63</i> 19 to <i>11-9-68</i> 19
that (I) (we) last saw the deceased alive on <i>11-5-68</i> 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>J. Bronus</i> | | | | 23B. DATE SIGNED
<i>11-9-68</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Jos. B. Bronus HAS, M.D.</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/13/68</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Deer Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Deer Park Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 15 1968</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR, ADDRESS
<i>Gerald M. Minnich Oakland, Md.</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 68-11470 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11470 | |
|--|------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Baby Boy Gower</i> | | | | 2. DATE AND HOUR OF DEATH
<i>11-3-68 1:05 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>37 Mercy Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>06-05</i>
C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>433 Hessel St.</i> | | | |
| 5. SEX <i>m</i> | 6. RACE <i>w</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-2-68</i> | | 9. AGE (In years lost birthday) <i>2 40</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hour: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>James Gower</i> | | | 14. MOTHER'S MAIDEN NAME <i>Margaret Demboezyk</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>MRS. L. FRANKIEWITZ 526 S. 46TH ST.</i> | | |
| 18. <i>769.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Prematurity</i>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Respiratory distress syndrome</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Prolonged rupture of maternal membranes.</i>
(C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 3/4 hours</i>
<i>2 3/4 hours</i>
<i>4 weeks</i> | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 2</i> 19 <i>68</i> to <i>Nov 3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov. 3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>S. Shin</i> M.D. DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>11-3-68</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>S. SHIN</i> | | | | 23D. ADDRESS <i>Mercy Hospital, Inc.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>11/4/68</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>NOV 15 1968</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farkas</i> | | 25C. FUNERAL DIRECTOR <i>2 Raymond L. Kaczorowski</i> | | ADDRESS <i>2525 Fleet St.</i> | |

1944-45

Project D

MS. 1. Transcripts

Paranormal

Respiratory distress syndrome

Psychological aspects of medicine

Rev. 2 Nov 62

11-2-62

X

Harvard Hospital, Boston

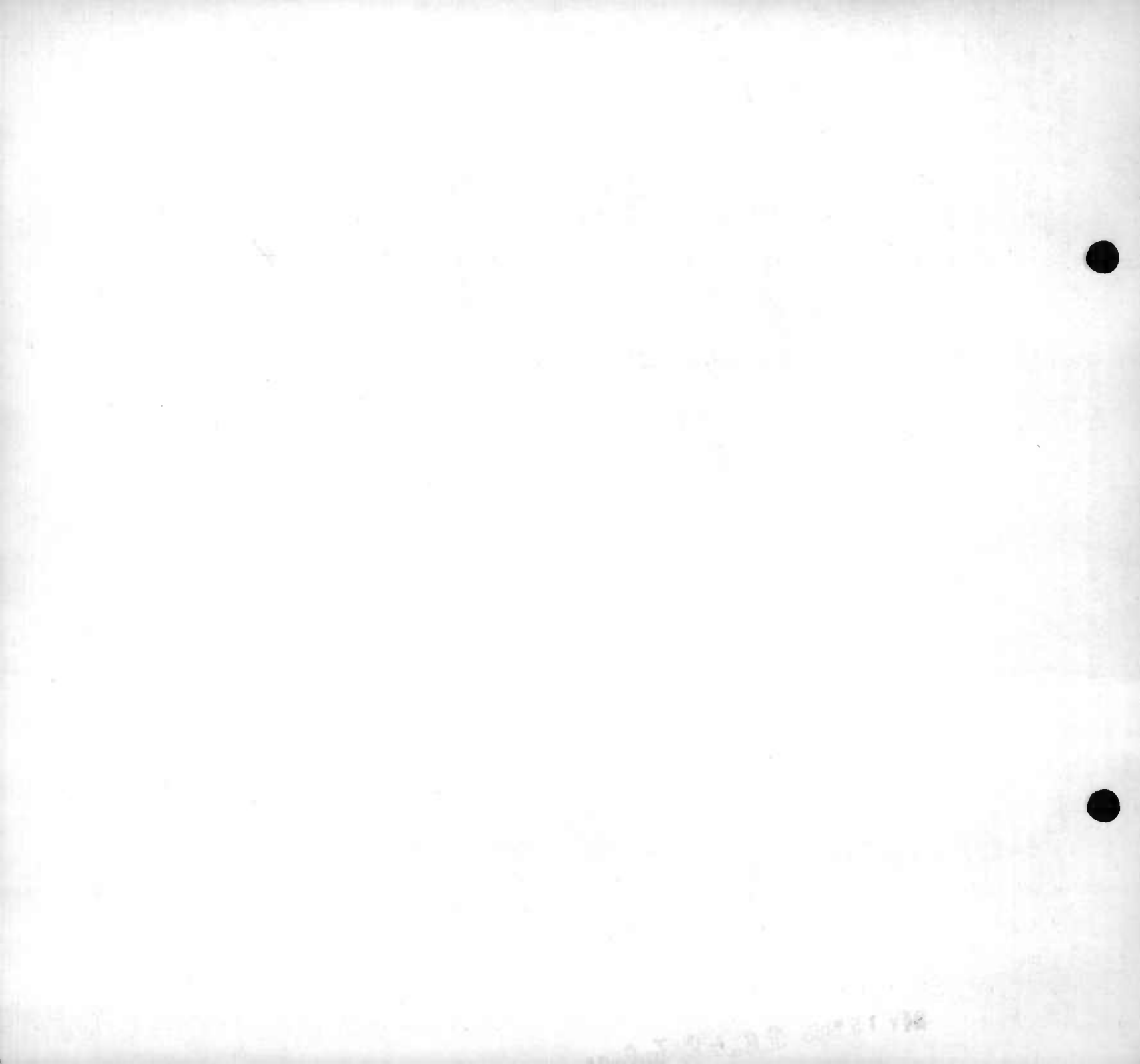
1. 10

S. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|--|--|--|--|--|--|
| G-635 | | 68-11471 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 68-11471 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Graydon, Walter Sixby</i> | | 2. DATE AND HOUR OF DEATH
<i>11/15/68 12:16 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>63-00</i> | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)
<i>Bon Secours Hospital</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Ellicott City Howard</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>15 Lombardi Dr.</i> | | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>5/3/14</i> | 9. AGE (In years lost birthday)
<i>54</i> | 10. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Salesman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Joseph George Graydon</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Biddle, MARIAN</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes - WWII - Army 312-07-3540</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMATION ADDRESS
<i>MARIAN E. GRAYDON Wife 15 Lombardi Dr.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Multiple metastases</i> | | | | CAUSE OF DEATH
(A) DUE TO
<i>Melanoma</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 months</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
<i>5 months</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION
<i>1968 11</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-31-68</i> to <i>11-15-68</i> , that (I) (we) lost saw the deceased alive on <i>11-14-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Graydon</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>11-15-68</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>JOSE G. AMAYO</i> | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11-18-68</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Woodlawn Cemetery - BALTO, Md</i> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 15 1968</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Jones</i> | | 25C. FUNERAL DIRECTOR
<i>Elkworth Armacost-4664 Lib. Hgts</i> | | ADDRESS | |

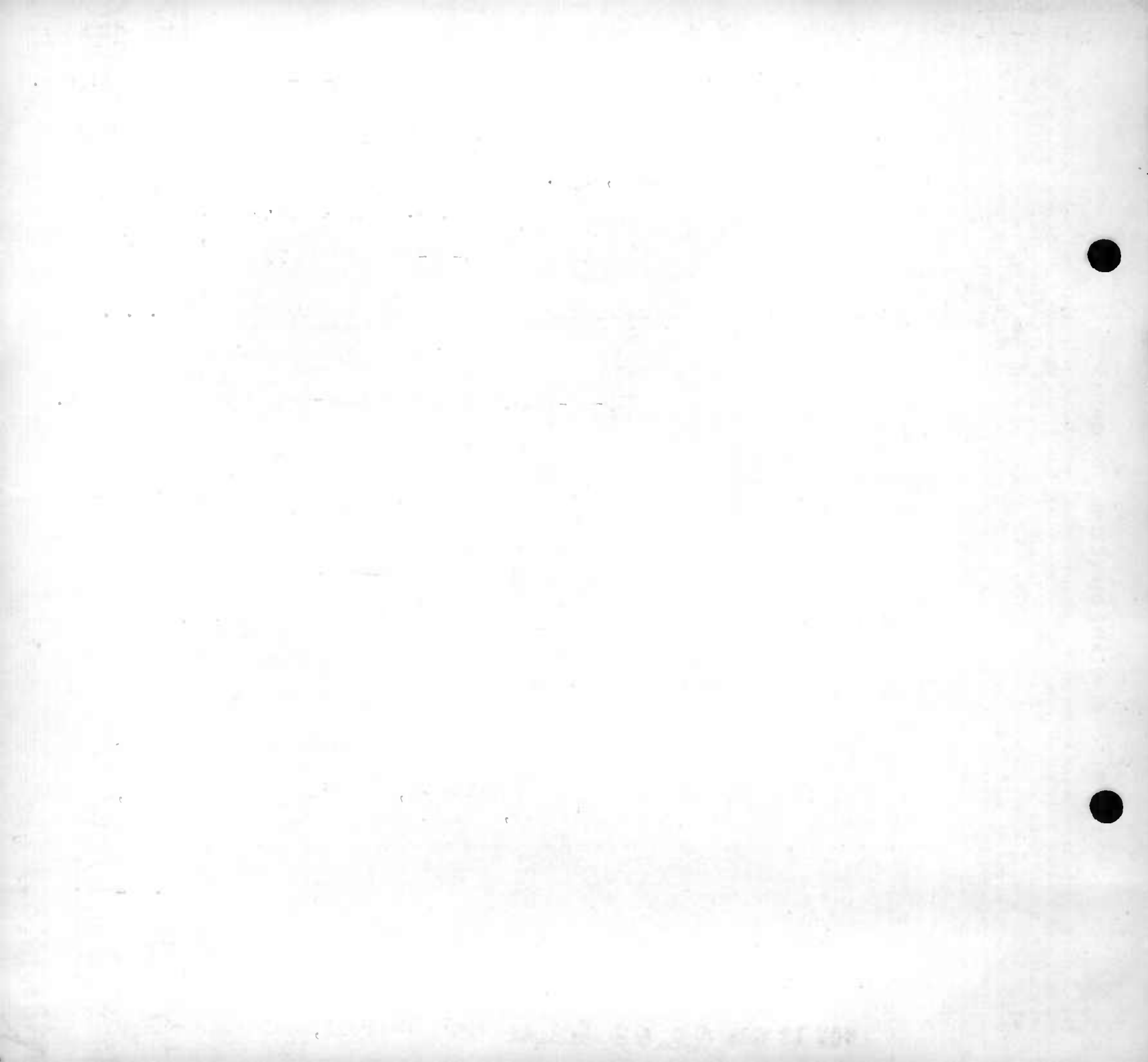


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|---|---|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | 68-11472 |
| 1. NAME OF DECEASED
(Type or Print)
Mattie Anderson | | | 2. DATE AND HOUR OF DEATH
11-15-68 3:30 a.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital, Inc. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 11-03 | | |
| | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
433 W. Biddle Street | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-11-89 | 9. AGE (In years lost birthday)
79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Housework | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
? | | | |
| 14. MOTHER'S MAIDEN NAME
Margaret Anderson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
? | | | |
| 16. SOCIAL SECURITY NO.
215-32-2112A | | 17. INFORMANT
1st Floor
Murray Walker-son 1220 McCulloh St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Generalized Atherosclerosis
Dissolved Molluscs
Arteriosclerotic Gangrene of Foot | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
260X II | | | | | |
| 19A. DATE OF OPERATION
3/11/13/68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gangrene of Foot | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 24, 1968 to November 15, 1968 , that (I) (we) lost saw the deceased alive on November 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Bernard Harris Jr. M.D. | | | | 23B. DATE SIGNED
11-15-68 | |
| 23C. PHYSICIAN'S NAME (Type)
Bernard Harris Jr. | | | | 23D. ADDRESS
1200 McCulloh St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/19/68 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jones | | 25C. FUNERAL DIRECTOR
I Carroll, Halstead Funeral Home | | | |
| 25D. ADDRESS
1206 W North Ave | | | | | |



G-650

68-11473 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11473

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
DELIA GREEN | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> November 14, 1968 11:15 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1358 N. Stricker Street (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 14, 1968 11:15 P. M. | |
| 6. SEX
Female | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
7-11-04 | | 10. AGE (In years last birthday)
64 | |
| 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF
U.S.A. | |
| 13. FATHER'S NAME
Salis Taylor | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1501 | |
| 15. STREET AND NUMBER
1358 N. Stricker Street | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) xxx | | 17. SOCIAL SECURITY NO.
212169840 | |
| 18. INFORMANT
John Taylor | | ADDRESS
same | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
412.7 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER xxx DATE SIGNED November 15, 1968
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-19-68 | |
| 24C. NAME OF CEMETERY or CREMATORY
Balto. Nat'l. Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Tuley | |
| 25C. FUNERAL DIRECTOR
V.R. Bailey | | ADDRESS
Kelson F. H. 1348 Calhoun Street | |

10-11-01

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10-11-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11474

| | | | | | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) HARDEN, Charles King | | 2. DATE AND HOUR OF DEATH
11/14/68 5:50 A | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland 8. COUNTY 13-012 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Md 21218 | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
2551 Madison Ave | | | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/9/19 | 9. AGE (In years lost birthday)
49 | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerical | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Clarence Harden | | | 14. MOTHER'S MAIDEN NAME
Bernice Hammond | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes 6/28/43 - 12/21/45 | | 16. SOCIAL SECURITY NO.
220-05-4000 | | 17. INFORMANT ADDRESS
VA Hospital Records Balto., Md | |
| 18. 491X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Emphysema
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Chronic Bronchitis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
3-02.0 II | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 29th 19 68 to November 14th 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 14th 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
Kay E. Gilmore, M.D. | | | 23B. DATE SIGNED
11/15/68 | | |
| 23C. PHYSICIAN'S NAME (Type)
KAY E. GILMORE, M.D. | | | 23D. ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-18-68 | | 24C. NAME of CEMETERY or CREMATORY
Balto. Nat'l. Cem. | |
| 24D. LOCATION
Balto. Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Kelso F.H. 1348 N. Calhoun St. | |

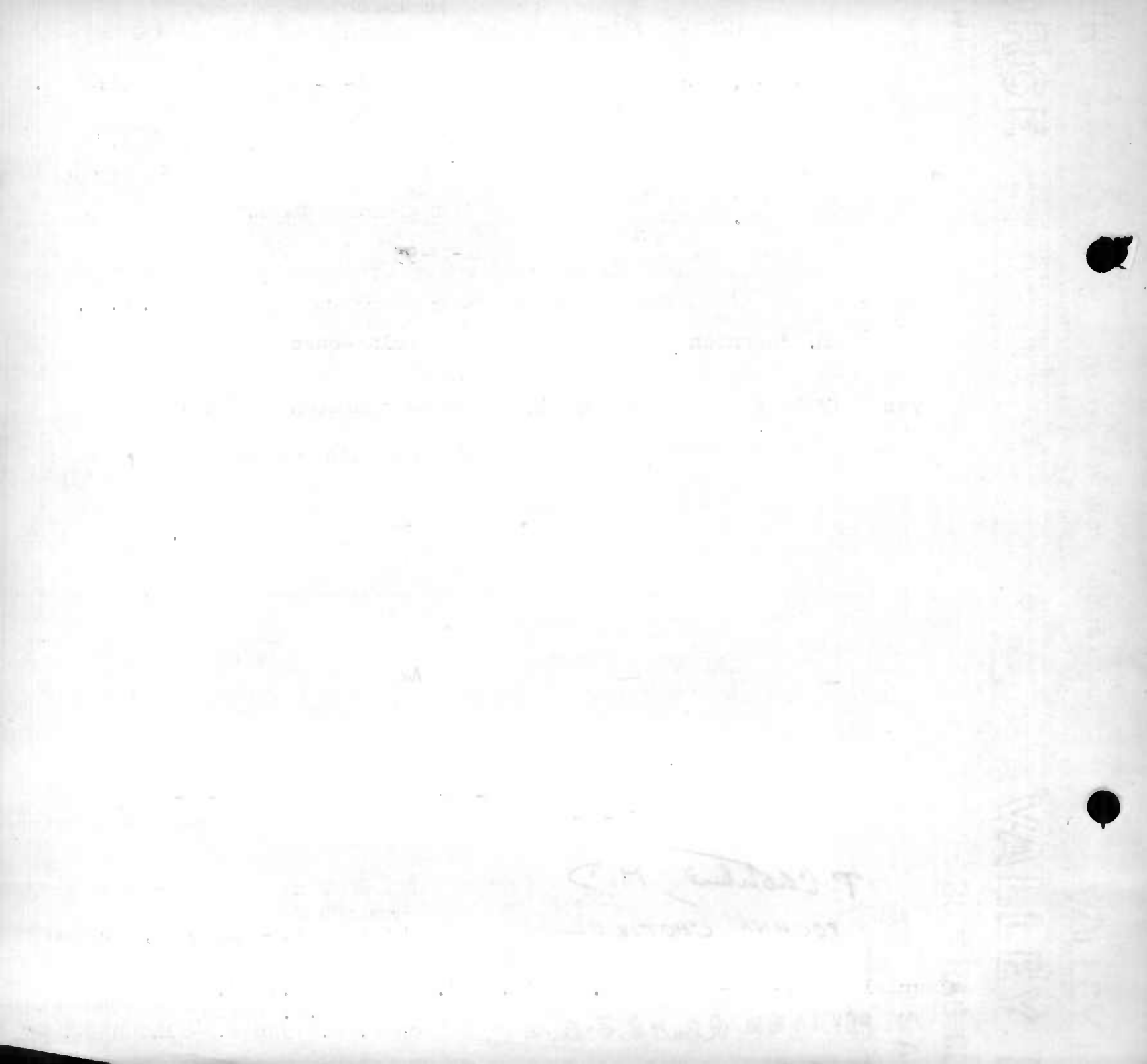
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11475 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-11475

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Thornton, Lucelles | | 2. DATE AND HOUR OF DEATH
11-16-68 11:30 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital
1514 Division Street
Baltimore, Maryland | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
1102 Clendenin Street | | 5. SEX
Male | | 6. RACE
Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-24-95 | | 9. AGE (In years last birthday) 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Southern States Cooperator | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Wm. Thornton | | 14. MOTHER'S MAIDEN NAME
Lula Jones | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes 1728598 | | 16. SOCIAL SECURITY NO.
216052777 | | 17. INFORMANT
Irene Thornton | |
| ADDRESS
same | | 18. CAUSE OF DEATH
1419 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Advanced C.A. tongue
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
1419 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-13-68 to 11-16-68 and that (I) (we) last saw the deceased alive on 11-16-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
P. Chotikul M.D.
OEGREE | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
11-16-68 | |
| 23C. PHYSICIAN'S NAME (Type)
POCHNA CHOTIKUL
OEGREE | | 23D. ADDRESS
Provident Hospital
1514 Division Street - Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-21-68 | | 24C. NAME OF CEMETERY or CREMATORY
Balto. Nat'l. Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
V.R. Bailey
Kelson F. H. 1348 N. Calhoun St. | | | |



S-530

68-11476

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-11476

BIRTH NO.

REG. NO.

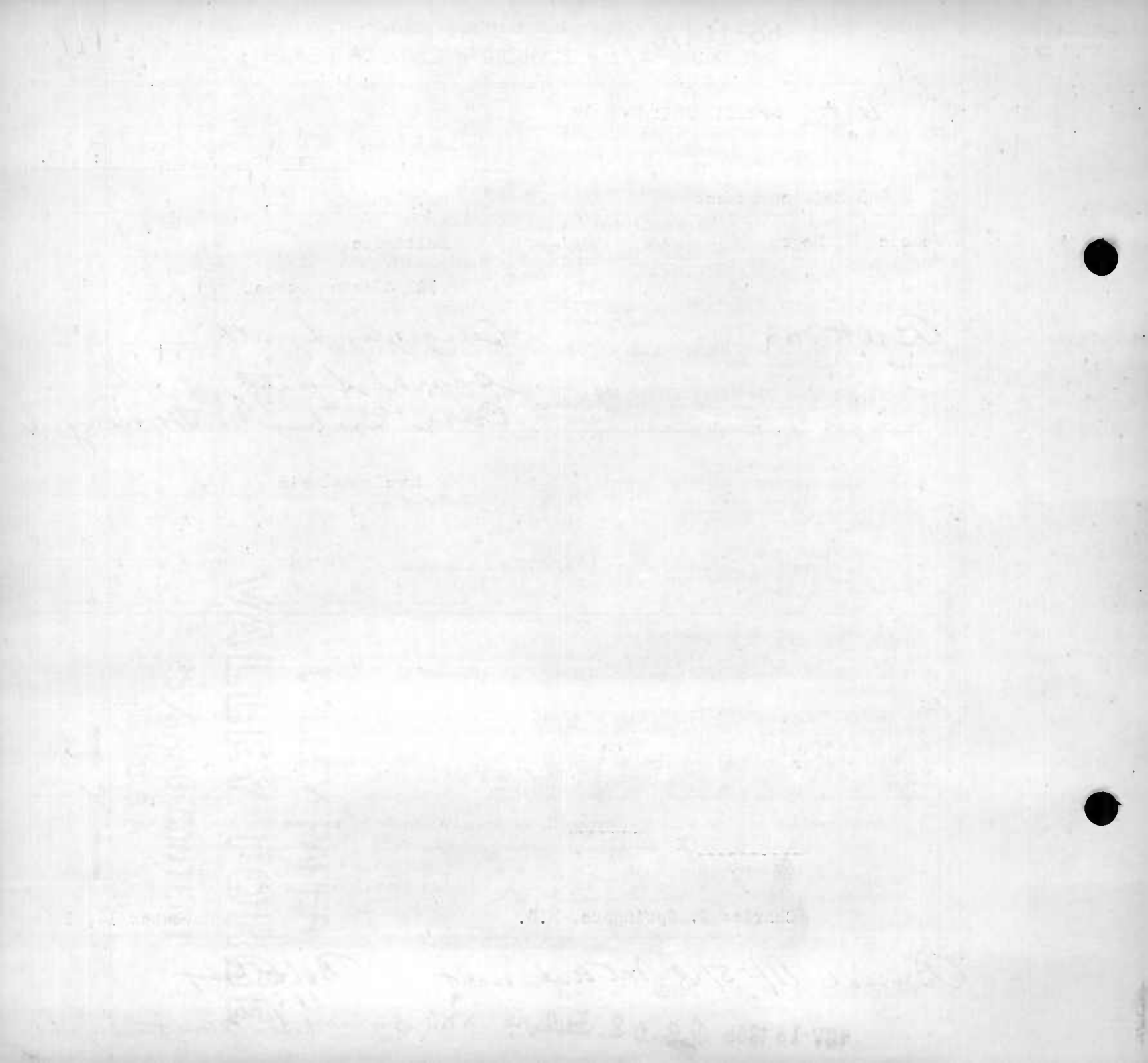
| | | | |
|---|-------------------------|---|---|
| 1. NAME OF DECEASED
(Type or Print) <u>Hattie NATTIE SMITH</u> | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>EISLEN ST</u>
<u>743 Elislen Street</u> | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
<u>November 13, 1968</u> <u>3:14 P.M.</u> | |
| 6. SEX
<u>Female</u> | 7. RACE
<u>Negro</u> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday)
<u>68</u> | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<u>Augustus Smith</u> | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
<u>Eva Graham W. Hamling</u> | | ADDRESS
<u>751</u> | |
| 19. <u>199.0 I</u>
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

<u>Carcinomatosis</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Charles S. Springate</u>
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
<u>November 14, 1968</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>11/15/68</u> | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>Mount Auburn</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 18 1968</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | |
| 25C. FUNERAL DIRECTOR
<u>H. Brown</u> | | ADDRESS
<u>108 W. ...</u> | |



P-412

68-11477 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11477

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLAUDE PHILLIPS

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

November 16, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 16, 1968

2:45 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

Nov 14-1943

10. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

726 N. Gilmore Street

11. BIRTHPLACE (State or foreign country)

Florence S.C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Phillips

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Not Cook Restaurant

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Harriet

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

705-10-9071

18. INFORMANT

ADDRESS

Dwight Phillips 726 N. Gilmore

19.

011.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Tuberculosis

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

008.1

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov 20-68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 18 1968

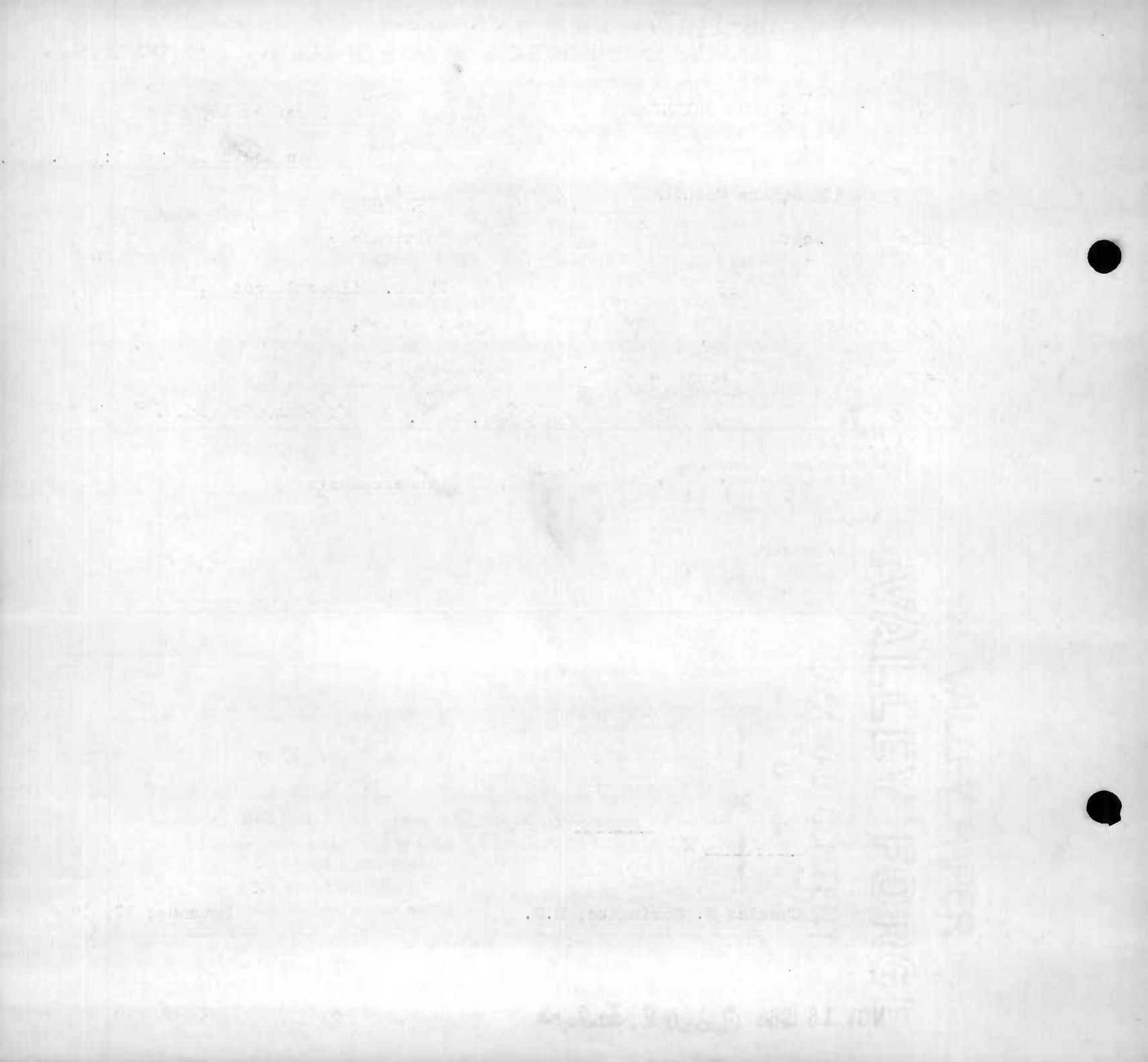
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Marshall P. Hayes 635 N. Gilmore St

ADDRESS



5530

68-11478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-11478

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>William Smith</i> | | 2. DATE AND HOUR OF DEATH
<i>11/14/68 1 30 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MARYLAND</i> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>BALTIMORE CITY HOSPITALS</i>
<i>4940 EASTERN AVENUE</i>
<i>BALTIMORE, MARYLAND 21224</i> | | C. CITY OR TOWN
<i>BALTIMORE</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>MALE</i> | | 6. RACE
<i>NEGRO</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<i>12-25-08</i> | | 9. AGE (In years last birthday)
<i>59</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>PENSIONED</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>VIRGINIA</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>RUBIN SMITH</i> | | | |
| 14. MOTHER'S MAIDEN NAME
<i>MARY SMITH</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>BCH:RECORDS BALTIMORE, MARYLAND # 21224</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
<i>427.01+230.9</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Pneumonia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Pulmonary Embolus, Recurrent</i> | | <i>4 week</i> | |
| (C) <i>Cong Heart Failure</i> | | | | <i>1 yr</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>434.1 II</i> | | <i>Diabetes Mellitus</i> | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/21/68</i> 19 <i>68</i> to <i>11/14</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/14</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Wm Mac Donald</i> | | | | 23B. DATE SIGNED
<i>11/14/68</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>WILLIAM MAC DONALD M.D.</i> | | 23D. ADDRESS
<i>BALTIMORE CITY HOSPITALS #21224</i>
<i>4940 EASTERN AVE. BALTIMORE, MD.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 24B. DATE
<i>11/19/68</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>CARVER MEM. PARK</i> | |
| 24D. LOCATION
<i>LAUREL MD</i> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<i>NOV 18 1968</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR
<i>WM C MARCH</i> | | | |
| ADDRESS
<i>928 E. NORTH AVE</i> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-11479 CERTIFICATE OF DEATH

REG. NO.

68-11479

| | | | | | |
|--|---------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JANE E. EVANS | | 2. DATE AND HOUR OF DEATH
11-14-68 11:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

44 UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE, 212
C. CITY OR TOWN BALTIMORE, 212
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 640 E. 29TH STREET | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-23-1900 | 9. AGE (In years lost birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
NOT KNOWN (NO INFORMANT) | | 14. MOTHER'S MAIDEN NAME
ELIZABETH NOT KNOWN (NO INFORMANT) | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-03-2477 | | 17. INFORMANT
WIFE Myrtle Paul | |
| 18. 1519 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CARCINOMA OF STOMACH & LIVER METASTASES
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
(A) IMMEDIATE CAUSE LIVER METASTASES DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. 137X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
NOV 10 1968 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA. OF STOMACH | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from NOV 9, 1968 19 to NOV 14 19 68 , that (I) (we) lost/saw the deceased alive on NOV 14 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
R. Salvilla
DEGREE | | | | 23B. DATE SIGNED
11-14-68 | |
| 23C. PHYSICIAN'S NAME (Type)
RICARDO SALVILLA
DEGREE | | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/18/68 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE RECEIVED
NOV 18 1968 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Tully | | 25C. FUNERAL DIRECTOR
WM MARCH | | | |
| 25D. ADDRESS
928 E. North Ave | | | | | |

11-14-68

11-14-68

11-14-68

UNITED STATES

DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

11-14-68

11-14-68

11-14-68

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES

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11-14-68

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 68-11480 4 | |
| BIRTH NO. 68-02242 | | 68-11480 | |
| 1. NAME OF DECEASED
(Type or Print) Baby Girl Fitzgerald | | 2. DATE AND HOUR OF DEATH
1:40 PM on 1/18/68 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2707 KIRK AVE | |
| 5. SEX F | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/16/68 |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) MD |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME UNKNOWN | |
| 14. MOTHER'S MAIDEN NAME ALICE FITZGERALD | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS HOSPITAL CHART | |
| 18. 772.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure
(B) PREMATURITY
(C) INTRAVENTRICULAR hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 331X II | | W. K. W. C. | |
| 19A. DATE OF OPERATION none | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) NO | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/16 19 68 to 1/18 19 68 , that (I) (we) last saw the deceased alive on 1/18 19 68 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Neil H. Kolsky M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED 1/18/68 |
| 23C. PHYSICIAN'S NAME (Type) NEIL H. KOLSKY M.D. | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | 24B. DATE 1-18-68 | 24C. NAME OF CEMETERY or CREMATOR CITY HEALTH DEPT | 24D. LOCATION (City, town, or county) BALTIMORE |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968 | | 25B. NAME OF REGISTRAR JOHN H. HOPKINS MEDICAL SCHOOL | |
| MORTUARY SERVICE - BCHD | | | |

1-18-68 City Health Dept.

Union Memorial Hospital

1-18-68

1-18-68

No

No

W.K.W.

Intravenous hypotonic

Prematurity

Respiratory Failure 24 hours

No

None

MD

F Negro

Union Memorial Hospital

1-18-68

49-51-01

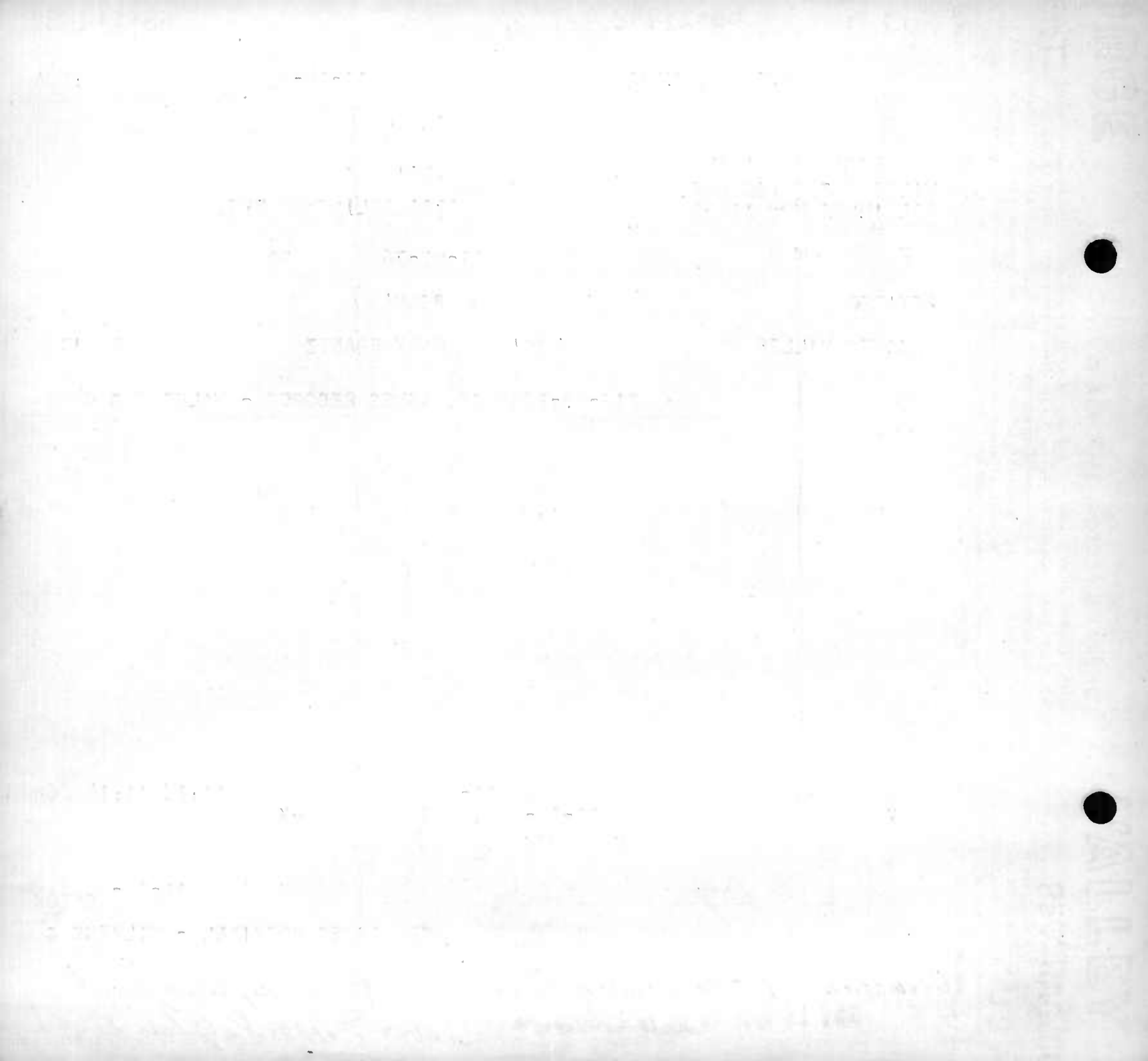
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 68-11481 | |
| 1. NAME OF DECEASED
(Type or Print) GERTRUDE E. HOWE | | | | 2. DATE AND HOUR OF DEATH
11/14/68 12 05 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 26-12 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224 | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
FEMALE | | | | 6. RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
7-3-96 | | 9. AGE (In years last birthday) 72 | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
WILLIAM HAWKINS | | | | 14. MOTHER'S MAIDEN NAME
THERESA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-54-4613 | | 17. INFORMANT RECORDS:
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
#21224 | | 18. ADDRESS | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CONGESTIVE HEART FAILURE
Acute Myocardial Infarction | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
420.1 II | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-14-19 67 to 11-14-19 68 , that (I) (we) last saw the deceased alive on 11/14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Philip A. Fraterreigo MD
DEGREE | | | | 23B. DATE SIGNED
11-14-1968 | | 23C. PHYSICIAN'S NAME (Type)
PHILIP A. FRATERREIGO, MD
DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
II-18-68 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county)
Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Sadyra | | 25C. FUNERAL DIRECTOR
WALTER DABROWSKI
ADDRESS
1005 DUNDALK AVENUE | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
|--|--------------|--|---------------------------------------|
| MYERS, EDWINA | | 11-14-68 8:20A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
WILKENS & CATON AVE.
BALTIMORE, MD. 21229 | | A. STATE
MARYLAND
B. COUNTY
Baltimore
C. CITY OR TOWN
BALTIMORE
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
1711 ARLINGTON AVE. 53-00 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-07-76 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 11. BIRTHPLACE (State or foreign country)
PENNA. | 9. AGE (in years last birthday)
92 |
| 13. FATHER'S NAME
JAMES MILLER DEC'D | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
215-48-3880 | |
| 17. INFORMANT
ST. AGNES RECORDS - WILKENS & CATON | | ADDRESS | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
412.4 I
Cerebral Coma.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Thrombosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
ASCVD - Generalized
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days | | 19. MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
420.1 II | |
| 19A. DATE OF OPERATION
D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 11-08 19 68 to 11:30 11:14 19 68, that (Y) (we) last saw the deceased alive on 11-14-19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Alejandro Mejia
DEGREE | | 23B. DATE SIGNED
11-14-68
CATON | |
| 23C. PHYSICIAN'S NAME (Type)
ALEJANDRO MEJIA B MD
DEGREE | | 23D. ADDRESS
ST. AGNES HOSPITAL - WILKENS & | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
11/16/68 | |
| 24C. NAME OF CEMETERY or CREMATORY
London Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR
Ambrose S. Sulpice Jr. | | ADDRESS | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

00-11483

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

PETER SIMMONS

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

11

14

68

4:03a.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November

14

1968 4:03a.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

80

E. STREET AND NUMBER

344 Gwynn Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

LABORER

GAS & ELECTRIC

AMY WESTBURY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

JAMES MOORE 344 GWYNN AVE

19. 160.2 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carcinoma of the nasal antrum
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

160.2 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

REMOVAL

11/17/68

Hope W ELL

SUMTER. S.C.

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

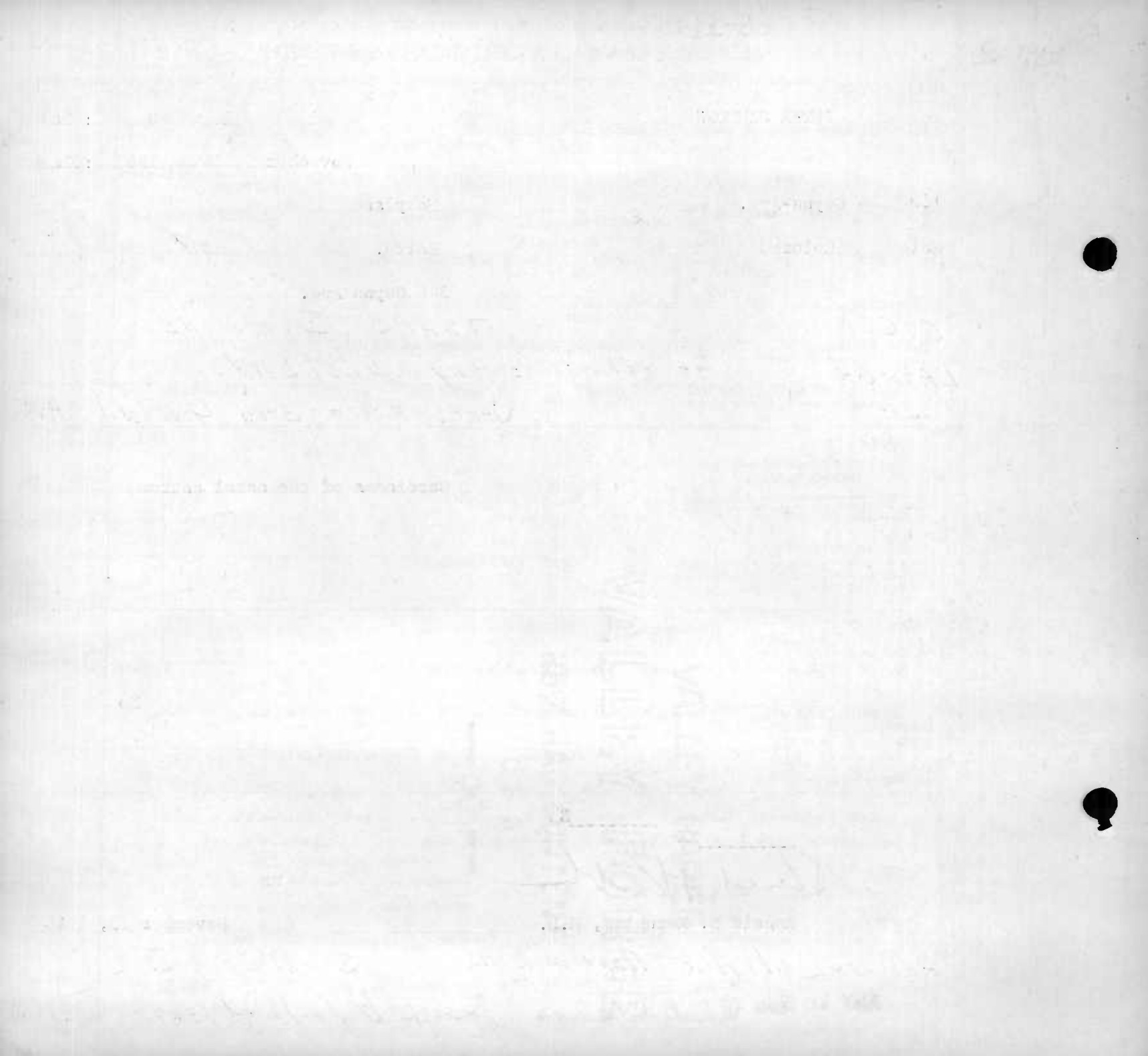
25C. FUNERAL DIRECTOR

ADDRESS

NOV 18 1968

Robert E. Fendley

Joseph B. Rock Jr 1304 N. Central Ave



1
D-000

68-11484 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11484

BIRTH NO.

| | | | | |
|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) ANNIE
ANNELL M. DYE | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
November 14, 1968 | | Hour
10:45 M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
1301 N. Central Avenue | | 3. DATE PRONOUNCED DEAD
Month Day Year
November 14, 1968 | | Hour
10:45 A. |
| 6. SEX
Female | | 7. RACE
Negro | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
5/9/03 | | 10. AGE (In years lost birthday)
65 | E. STREET AND NUMBER
1301 N. Central Avenue | |
| 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | 13. FATHER'S NAME
DICK DYE | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
ELIZA JOHNSON |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
MARY TURNER 1313 N. Brant St |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
No |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23.
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 14, 1968 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/19/68 | | 24C. NAME OF CEMETERY or CREMATORY
mt. Calvary |
| 24D. LOCATION (City, town, or county)
A. A. County Md | | 24E. FUNERAL DIRECTOR
Joseph B. Lock | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
R. S. S. Jenkins | | 25C. ADDRESS
1304 N. Central Ave |

WALLLEY POLICE

RECEIVED

NOV 14 1964

OFFICE OF THE SHERIFF

NOV 14 1964

4220

68-14485

BALTIMORE CITY HEALTH DEPARTMENT

68-14485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) LEROY HUGHES | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> November 16, 1968 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Johns Hopkins Hospital (DOA) | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
November 16, 1968 11:29 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 6-01 | | | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
May 4th. 1918 | | 10. AGE (In years last birthday) 49 50 | | E. STREET AND NUMBER
439 N. Robinson Street | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Hughes | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
218-01-9265 | | 18. INFORMANT ADDRESS
Mrs. Louise V. Hughes 439 N. Robinson St. | |
| 19. 412.41
CAUSE OF DEATH
Arteriosclerotic cardiovascular disease
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) _____ | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE: <i>Charles S. Springate</i> M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: November 17, 1968 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Nov. 19 /68 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS
Philip Herwig Sons 2024 Orleans St. | |

WILLIAM DOUGLAS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11486

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print)
ELLA ROSE HARRIS | | 2. DATE AND HOUR OF DEATH
NOV. 16, 1968 5 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 THE JOHNS HOPKINS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX FEMALE 6. RACE NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-24-1903 9. AGE (In years last birthday) 65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 13. FATHER'S NAME
WILLIAM FARABEE | | 14. MOTHER'S MAIDEN NAME
ELLA ZAMITH HARRISTON | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Dorothy Farabee 1305 Wildwood Pkwy | |
| 18. 450X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
PULMONARY EMBOLUS | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
PULMONARY EMBOLUS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS - 2 WKS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) _____
DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | |
| 19. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 12, 1968 to Nov 16, 1968 , that (I) (we) lost saw the deceased alive on Nov 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael D. Lutz, M.D. | | 23B. DATE SIGNED
Nov. 16, 1968 | | 23C. PHYSICIAN'S NAME (Type)
MICHAEL D. LUTZ, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-20-68 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR
Marshall W. Jones, Jr. | | 25D. ADDRESS
1735 Harford Av | | | |

MICHAEL D. LUTS, M.D.
Michael B. Lutz, M.D.

Nov 16 08
Nov 15 08

Nov 16 08

Nov 16 08

Primary Embolus

2 Days - 2000

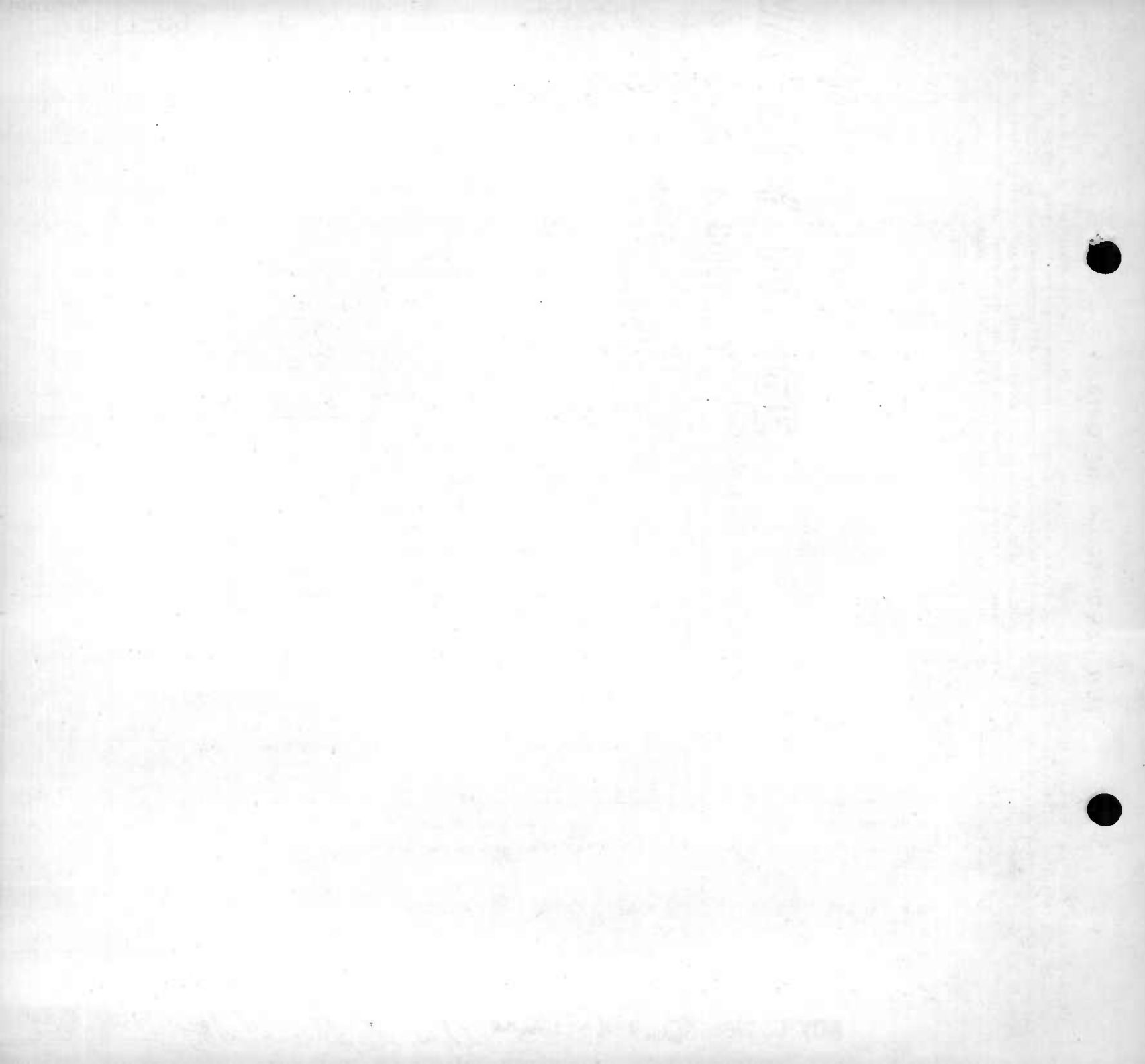
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11487 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11487

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Anthony (Antonius) M. SITSKORN | | 2. DATE AND HOUR OF DEATH
11-15-68 11 25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
43 South Baltimore General Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 11/12/95 9. AGE (In years last birthday) 73 | |
| 11. BIRTHPLACE (State or foreign country)
Holland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME Antonius SITSKORN | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. 215-09-3321 | |
| 17. INFORMANT Mrs. Betty Bender | | ADDRESS 1450 Andre St. | | 18. IX I
CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Prostate & widespread metastases | | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 177X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 11-15-1968 to 11-15-1968 , that (I) (we) lost the deceased alive on 11-15-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Stanley R. Weimer, M.D. | | 23B. DATE SIGNED 11-15-68 | | 23C. PHYSICIAN'S NAME (Type) Stanley R. Weimer M.D. | |
| 23D. ADDRESS South Baltimore General Hosp. Md. | | 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 11/18/68 | |
| 24C. NAME OF CEMETERY Glenn Haven Memorial Park | | 24D. LOCATION (City, town, or county) (State) Anne Arundel, Md. | | 25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968 | |
| 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR Charles L. Stevenson | | ADDRESS 1501 E. Pratt | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11488

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH HALL

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

October 19, 1968

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

October 19, 1968

1:12 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

10. AGE (In years
last birthday)

61 ?

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

318 N. Poppleton Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. E814.17

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple severe injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

E812.4 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Mulberry St. west of Poppleton St.

22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10-19-68 1:00 A.M.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Run over by car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 19, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

11-8-68

24C. NAME of CEMETERY or CREMATOR

25A. DATE REC'D

NOV 18 1968

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

October 12, 1900

Dear Sir:

Enclosed find

check for \$10.00

Yours

Very truly yours,

WALTER H. HARRIS

1900

Walter H. Harris, M.D.

and

Walter H. Harris, M.D.

Walter H. Harris, M.D.

October 12, 1900

Walter H. Harris, M.D.

Walter H. Harris, M.D.

Walter H. Harris, M.D.

W-8-02

Walter H. Harris, M.D.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) OSCAR GROSS | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour
October 7, 1968 10:20 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
37 Mercy Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
October 7, 1968 10:20 A.M. | |
| 6. SEX
Male | 7. RACE
White | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 4-01 | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday)
60 | | E. STREET AND NUMBER
704 E. Baltimore Street | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 15. MOTHER'S MAIDEN NAME | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |

| | | | | | |
|-----------------------|---|--|--|--|--|
| MEDICAL CERTIFICATION | 19. 250.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Bilateral bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF:
(B) Diabetic coma
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | 20. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes |
| | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| | ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED October 7, 1968 |
| | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 11-8-68 | | 24C. NAME OF CEMETERY or CREMATORY |
| | 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF CEMETERY or CREMATORY | | 24F. LOCATION (City, town, or county) (State) |
| | 25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD |

WALL L...

UNIVERSITY MEDICAL SCHOOL

LIBRARY SERVICE - BLDG. 11-2-68

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11490

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
Alice Forewood | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> 10 26 1968
Hour 4:00 PM. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hospital
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
10 26 1968 4:45 PM. | |
| 6. SEX
F | | 7. RACE
W | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
68 | | 10. AGE (In years lost birthday)
68 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardio vascular disease.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 10/27/68 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
11-8-68 | |
| 24C. NAME OF CEMETERY or CREMATOR | | 24D. LOCALITY (City, town or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

UNITED STATES DEPARTMENT OF THE ARMY
HOSPITAL SERVICE
UNITED STATES DEPARTMENT OF THE ARMY
HOSPITAL SERVICE

11-8-48

NOV 11 1948

VALLEY FORGE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11491

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) DAVID W. McCALLUM | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month 10 Day 8 Year 68 Hour 6:15 p. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
00 3301 Ferndale Ave. D.O.A. | | 3. DATE PRONOUNCED DEAD
Month October Day 8 Year 1968 Hour 6:15 p. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH | | 10. AGE (in years lost birthday) 47 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |
| 19. 3-71.8
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fatty liver
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson, M.D. M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 11-12-68 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 18 1968 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS BCHD | |

11-12-62

UNIVERSITY MEDICAL SCHOOL
DURHAM, NORTH CAROLINA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 68-11492 |
|---|---------|--|------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | JAKE. B. Jennings Jr. | | 11/06/68 12 45 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | 5. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | Maryland. | |
| Union Memorial Hospital | | | | CITY OR TOWN | |
| | | | | Baltimore | |
| | | E. STREET AND NUMBER | | D. INSIDE CITY LIMITS? | |
| | | 2106 N. Calvert St. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | NEGRO | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8/14/08 | 60 | 3 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | South Carolina | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Jake B. Jennings Sr. | | Bertha | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 249-12-2178 | | Mrs. Ada Jennings, 113 N. Culver St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | ASCVD. | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 422.1 II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 8/21 1968 to 11/6 1968, that (H) (we) last saw the deceased alive on 10/14 1968 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| David S. Schwartz | | | | 11/6/68 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | ANATOMY BOARD OF MARYLAND | |
| | | | | UNIVERSITY MEDICAL SCHOOL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | | | BALTIMORE | |
| 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24E. FUNERAL DIRECTOR | |
| 11-79-68 | | Carver Mem. Park | | Marshall P. Hayes | |
| 4-14-68 | | Muirkirk, Md. | | ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 18 1968 | | Robert E. Jenkins | | MORTUARY | |
| | | | | 638 N. Gilmer St. | |

11/10/11

11/10/11

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11/10/11

1
5-530

68-11493 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-11493

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
JAMES JEFFERSON SMITH | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input checked="" type="checkbox"/> September 27, 1968 1:50 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Harbor at Calvert St. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
September 27, 1968 1:50 A.M. | |
| 6. SEX
male | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| 7. RACE
negro | | C. CITY OR TOWN
Baltimore | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (in years last birthday)
42 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |
| 19. CAUSE OF DEATH
E 95 14 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Drowning
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No)
No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
water | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Baltimore Harbor at Calvert St. | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
9/27/68 1:35 A. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subj. jumped in harbor | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 9/27/68 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
11-12-68 | |
| 24C. NAME OF CEMETERY or CREMATOR | | 24D. NAME OF CEMETERY or CREMATOR | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Spitz | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

[Handwritten signature]

11-1248

UNIVERSITY MEDICAL SCHOOL
DEPARTMENT OF MEDICINE
1001 UNIVERSITY AVENUE
ANN ARBOR, MICHIGAN 48106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-11494

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) CARROLL WOOLERY | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> October 10, 1968 8:50 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CHURCH HOME AND HOSPITAL (BOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
October 10, 1968 8:50 P. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) 52
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |

| | | | |
|--|--|-------------------------------------|--|
| 19. 412.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |

| | | |
|--|---|--|
| 20A. DATE OF OPERATION
2 | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21. AUTOPSY? (Yes or No)
yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR? |

| | |
|---|--|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Ronald N. Kornblum, M.D.
EXAMINER'S NAME (Type) | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
October 11, 1968 |

| | | | |
|---|--|---|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
11-8-68 | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | 25B. NAME OF REGISTRAR
Robert E. Fuchs | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | ADDRESS |

11-2-28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11495 | 7 |
|--|---------------------|--|---|--|---|
| BIRTH NO. 68-21391 | | 68-11495 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
BABY GIRL WHITACKER | | | 2. DATE AND HOUR OF DEATH
11/9/68 12:25 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE Co | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL | | | C. CITY OR TOWN
PIKESVILLE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER
23 WALKER AVE | | 53-00 |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-8-68 | 9. AGE (In years lost birthday)
— | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
— — 3 4 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
BALT MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA. |
| 13. FATHER'S NAME
ROBERT WHITACKER | | | 14. MOTHER'S MAIDEN NAME
DOROTHY ELIZABETH FLENCKE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
— | 17. INFORMANT ADDRESS | | |
| 18. 776.1 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE PREMATURITY
DUE TO, OR AS A CONSEQUENCE OF:

(B) HYALINE MEMBRANE
DUE TO, OR AS A CONSEQUENCE OF:

(C) CS. | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
773.5 II | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/8/68 19 68 to 11/9 19 68 , that (I) (we) last saw the deceased alive on 11/9/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. Alvarez | | | 23B. DATE SIGNED
11/9/68 | | |
| 23C. PHYSICIAN'S NAME (Type) MIRTHA ALVAREZ MD.
DR. ALVAREZ | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL
ANATOMY BOARD OF MARYLAND | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
11/14/68 | | 24C. NAME OF CEMETERY or CREMATORY
UNIVERSITY MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |

DOWNWARD EXHAUST OF 12.5

DOWNWARD EXHAUST OF 12.5

PRELIMINARY
FIREWORKS

1/1

1/1

1/1

1/1

1/1

1/1

1/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11496

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-11496

| | | | | | |
|---|---------------------|--|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) GEORGE CRAWFORD | | 2. DATE AND HOUR OF DEATH
7:00 11/8/68 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____ | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 MERCY Hosp | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTO | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
814 ST. PAUL ST. | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/21/80 | 9. AGE (In years, last birthday)
88 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 486X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
PNEUMONIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCUD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24' | |
| 19. 493X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 8 1968 to Nov 8 1968 , that (I) (we) lost saw the deceased alive on Nov 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. Susan Bollinger | | | | 23B. DATE SIGNED
Nov. 11/68 | |
| 23C. PHYSICIAN'S NAME (Type)
M. Susan Bollinger | | 23D. ADDRESS
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE
11/14/68 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | | 25B. NAME OF REGISTRAR
R. B. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE .. BCHO | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>68-11497</u> |
|--|-------------------------|---|------------------------------------|--|
| BIRTH NO. <u>68-21352</u> | | 68-11497 | | CERTIFICATE OF DEATH |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Henry Owens</u> | | 2. DATE AND HOUR OF DEATH
<u>November 7, 1968</u> <u>11:35 a. m.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

<u>Provident Hospital, Inc.</u>
<u>1514 Division St.</u>
<u>Baltimore, Maryland 21217</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY _____
C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2106 Etting St.</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-7-68</u> | 9. AGE (In years lost birthday) _____
If Under 1 Yr. Months: _____ Days: _____
If Under 24 Hrs. Hours: <u>4</u> Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Richard Owens</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Louise Compton</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mother</u> | | |
| 18. ADDRESS
<u>Same</u> | | 19. CAUSE OF DEATH | | |
| 1B. <u>776.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>Anoxia</u>
DUE TO, OR AS A CONSEQUENCE OF:

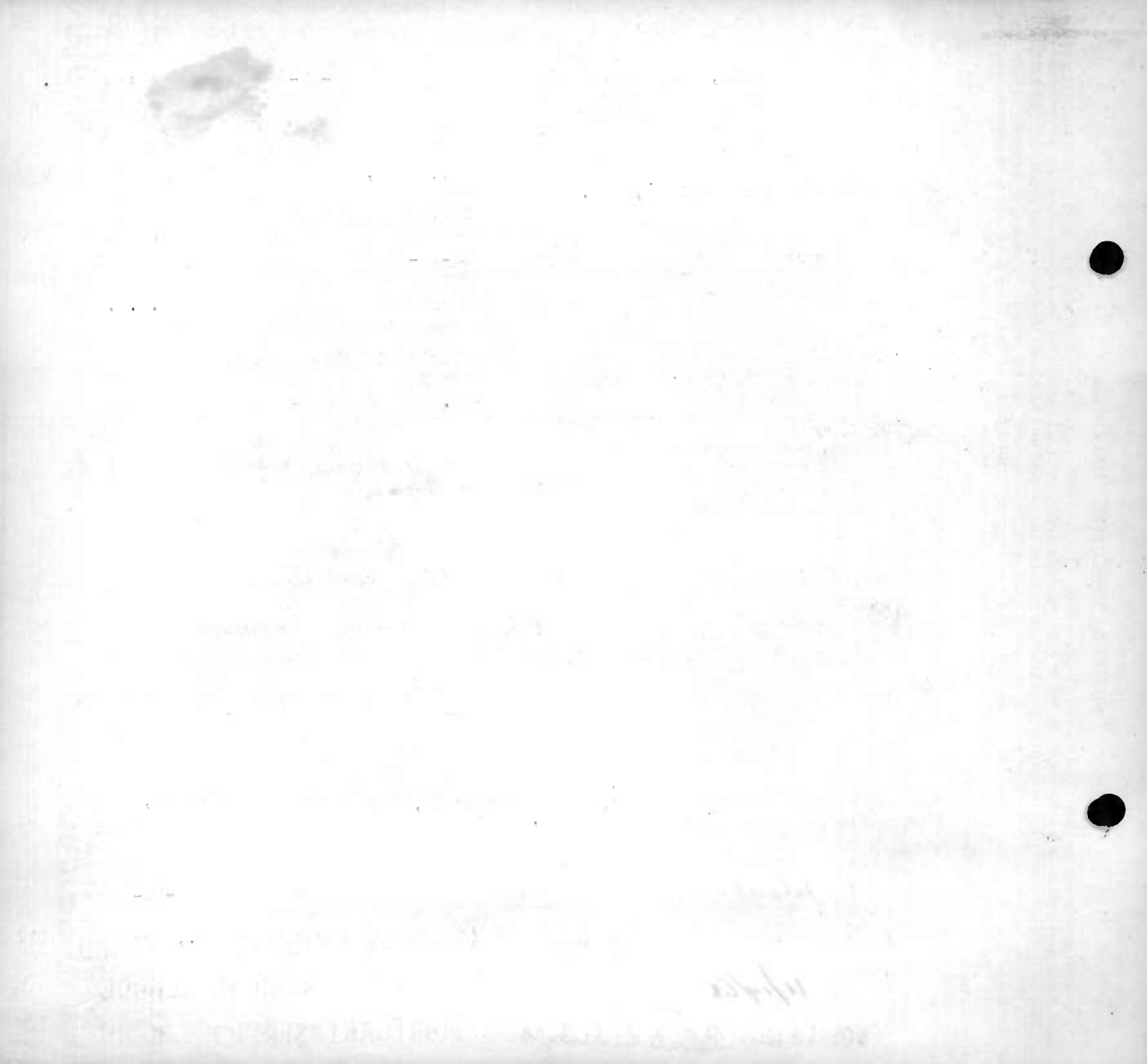
(B) <u>Prematurity</u>
DUE TO, OR AS A CONSEQUENCE OF:

(C) <u>Pulmonary Hyaline Membrane Disease</u> | | |
| 19. HEMORRHAGIC DISEASE OF THE NEWBORN | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-7-68</u> to <u>11-7-68</u> , that (I) (we) last saw the deceased alive on <u>11-7-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Teresita A. Cacha, M.D.</u> | | 23B. DATE SIGNED
<u>11-12-68</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Teresita A. Cacha, M. D.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>11/14/68</u> | | 24C. NAME OF CEMETERY or CREMATORY |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR
<u>MORTUARY SERVICE - BCHD</u> |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11498 | |
|--|--|---|--|--|--|
| BIRTH NO. 68-20820 | | 68-11498 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. SEX | |
| Bell, Baby Girl | | 10-29-68 | | Female | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. RACE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital, Inc. | | A. STATE
Maryland | | Negro | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| | | C. CITY OR TOWN
Baltimore, | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8. DATE OF BIRTH
10-29-68 | |
| | | E. STREET AND NUMBER
2037 Kennedy Avenue | | 9. AGE (In years lost birthday)
1 20 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 13. FATHER'S NAME
Melburn Bell | | 14. MOTHER'S MAIDEN NAME
Valerie Michelle Anderson | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Valerie Bell- mother | |
| | | | | ADDRESS
SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 261.9 I | | Asphyxia neonatorum | | 1 hr. | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Prematurity | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | Maternal drug addiction | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 269.9 II | | Polycystic Kidney, Congenital | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 29, 1968 to October 29, 1968, that (I) (we) last saw the deceased alive on October 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
P. SETASUBAN M.D. | | 23B. DATE SIGNED
10-30-68 | | 23C. PHYSICIAN'S NAME (Type)
P. SETASUBAN M.D. | |
| | | | | 23D. ADDRESS
1501 D... St. Baltimore, Maryland 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
11/14/68 | | 24C. NAME of CEMETERY or CREMATORY | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |
| | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 68-11499 |
|--|---|--|--|--|
| 68-11499 | | | | CERTIFICATE OF DEATH |
| BIRTH NO. 18-21216 | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY GRIZZELL | | 2. DATE AND HOUR OF DEATH
11-11-68 4:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME AND HOSPITAL
35 | | A. STATE Balt Co B. COUNTY 53-00 | | |
| | | C. CITY OR TOWN Balt D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER 6884 Dumbear Rd | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-11-68 | 9. AGE (In years last birthday)
12 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
SAMMY FARRELL GRIZZELL | | 14. MOTHER'S MAIDEN NAME
SHIRLEY ANN HENSLEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| 18. 777 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PREMATURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
776 X II | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-11-68 6:03 AM to 11-11-68 4:55 PM , that (I) (we) lost saw the deceased alive on 11-11-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Copeland - Feeley | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) |
| 23D. ADDRESS | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
11/14/68 | 24C. NAME OF CEMETERY or CREMATORY | | |
| 24D. LOCATION (City, town or county) (State) | | 24E. LOCATION (City, town or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 18 1968 | 25B. NAME OF REGISTRAR
Robert E. Johnson | 25C. FUNERAL DIRECTOR ADDRESS
MORTUARY SERVICE RCHD | | |

Handwritten text, possibly a date or reference number, located in the upper middle section of the page.

Handwritten text, possibly a title or subject line, located in the middle section of the page.

Handwritten text, possibly a name or signature, located in the lower middle section of the page.

Handwritten text, possibly a date or reference number, located in the lower left section of the page.

Handwritten text, possibly a name or signature, located in the lower right section of the page.

Handwritten text, possibly a date or reference number, located in the bottom right section of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-11500 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

| | | | | | |
|---|------------------|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Kurt R. Jarmer | | 2. DATE AND HOUR OF DEATH
2:30 PM 11-14-68 2:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY ANNE ARUNDEL 52-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
MD. General Hospital 48 | | | | C. CITY OR TOWN Mt. Airy D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER Box 169 Elvaton Rd. | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH 8-23-08 | 9. AGE (In years lost birthday) 60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
SHIP BUILDING | | 11. BIRTHPLACE (State or foreign country)
Germany | 12. CITIZEN OF WHAT COUNTRY?
GERMANY |
| 13. FATHER'S NAME
Heinrich Jarmer | | | | 14. MOTHER'S MAIDEN NAME
? UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215055290 | | 17. INFORMANT ADDRESS
Hosp. information sheet | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
442 IX Cardiorespiratory arrest | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
452 X II Intracerebral catastrophe 11-8-68 | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) Aneurysm, ? Infection. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
10-68 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mass lesion | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/8 1968 to 11/14 1968 , that (I) (we) last saw the deceased alive on 11/14 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Marvin C. Sachs, MD | | | | 23B. DATE SIGNED
11-14-68 | |
| 23C. PHYSICIAN'S NAME (Type)
MARVIN C. SACHS | | | | 23D. ADDRESS
MD. Gen. Hosp | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/18/68 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | |
| 25A. DATE REC'D.
Nov 18 1968 | | 25B. NAME OF REGISTRAR
Robert E. Tedders | | 25C. FUNERAL DIRECTOR ADDRESS
Raymond C. Fink Glen Burnie, Md. | |

Amey, J. W. 11-8-8
Lithological description
Cath. 11-8-8
Cath. 11-8-8
Cath. 11-8-8

[Handwritten signature]